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1522 Sherbrooke Street West, Montreal 25, Quebec.

Member of Canadian Circulations Audit Board.

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Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.
For subscribers in Canada, in combination with the
American Journal of Nursing: 1 year, $8.00; *Nursing Outlook:* 1 year, $7.00.
Make cheques and money orders payable to The Canadian Nurse.
Change of address: Four weeks' notice and the *old* address as well as the new are necessary.
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Between Ourselves

Thinking over a suitable introduction to this column this morning, we counted up on our fingers the number of years we have bid farewell to an old year and greeted a new one in this fashion. This is our *seventeenth* Christmas issue! Since the December issue of 1944 there has been such tremendous expansion in nursing activities and in the *Journal* itself, that one is inclined to look back, almost with nostalgia, to the relatively carefree days of a 72-page issue and some six thousand subscribers.

Our work-load and the staff to carry it 17 years ago was similar to that of our CNA National Office and the offices of the provincial nurses' associations. We had one editor and three clerks; National Office one general secretary and two clerks. Today, each of these branches of the Canadian Nurses' Association has a full-time staff of 14. The volume of work has grown to the point that more pairs of hands, more active minds are imminently required.

One of our longed-for goals was to reach "60 (thousand subscribers) in '60." We can joyfully report that that total has been reached and surpassed. In fact, our estimate is that the total joint circulation for this month's issue will be well in excess of 61,000. Quite an increase from the 6,041 subscribers of 1944!

What goal should we set next? Your guess is as good as ours. With most of the schools of nursing reporting that this fall's student enrolment is larger than ever before in their history; with increasing hundreds of wartime babies reaching the age when they are ready to launch into their chosen careers in nursing; with government-sponsored hospital care programs in active operation in most areas of our country calling for more and more staff members, we would hesitate to hazard a guess as to the probable total number of nurses who will be members of the Canadian Nurses' Association and subscribers to *The Canadian Nurse* two, five or ten years from now.

* * *

You had an opportunity in October to read the thoughtful addresses on the results of the initial examination that was made of the need for and the usefulness of a program of evaluation of schools of nursing in Canada. An expert in this field of study, Dr. **Helen Nahm**, analyzed Miss Mussallem's Report and sketched a broad series of "next steps" in the course of her address to the convention body. We are pleased to be able to share this address with you for it will most certainly help you to understand the developments that must occur within the next few years if effective results are eventually to be achieved.

One of the important things to note, in your reading of this article, is Dr. Nahm's warning of the differences of opinion regarding the need for change that will almost inevitably arise. Already, murmurs of opposition have been heard from some of the groups that Dr. Nahm mentions. Before pressures begin to build up in any direction, *do* read Miss Mussallem's report yourself, then study Dr. Nahm's analysis of Recommendation I. Don't you be the nurse who doesn't know what it is all about. This *is* our business as professional women.

* * *

Many manufacturers of hospital equipment and supplies have a firmly fixed idea that nurses have little or no choice or say in what kinds or brands of material will be ordered. From our own observations and especially, from comments made to us by matrons of some of the smaller hospitals, by operating room supervisors and those in charge of central supply rooms, we have vigorously challenged the manufacturers' opinions. What do you say?

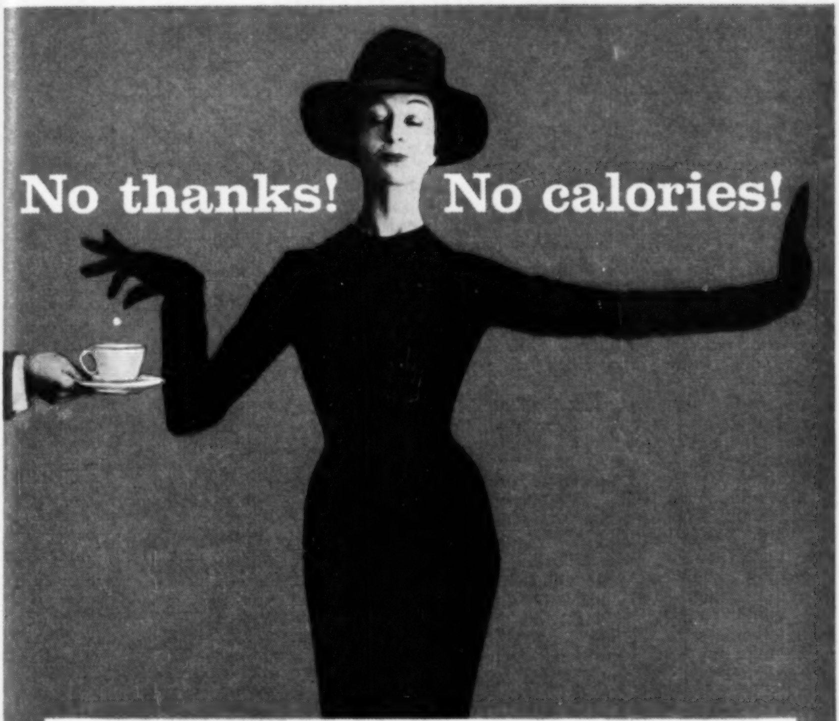
The pair of articles dealing with hospital purchasing bears out our contention, we believe, that the advice and recommendation of nurses are sought more often than not, even in the largest hospitals with ably functioning purchasing departments. Since this matter has an important bearing on advertising in our *Journal*, we would welcome your opinions.

* * *

And now, goodbye to 1960 and volume 56! In the midst of your preparations for Christmas and the New Year celebrations, we send you our sincere good wishes.

HAPPY CHRISTMAS TO YOU ALL.

The lighted wreaths in windows at Christmas time are credited to the Irish.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Random Comments

Dear Editor:

I am writing in answer to Jane Lewis' letter that appeared in the September issue of the *Journal.* The article "Bed-Pan Hands" in the June issue, referred to long exposure of skin to the disagreeable effects of soap, i.e. defatting the skin. This is, of course, undesirable in general skin care. Bedsores, however, require "special" care.

In Harmer and Henderson's *Textbook of the Principles and Practice of Nursing,* 5th ed. page 498, concerning bedsores it states "Next to an adequate diet and the relief of pressure, absolute cleanliness is the most important preventive measure." These are also the measures used in the care of a bedsore.

The step that follows cleanliness is keeping the area dry. Laundry soap was used, in four hospitals in which I have worked, for both of these steps. The drying effect of soap in the care of a bedsore is desirable, whereas it is undesirable in hand care or general skin care.

In treating an open bedsore there is always a need to prevent infection and promote healing. Although I have never used the foam treatment, I was taught not to wash off the soap but rather to pat the area dry after soaping. I regret that I do not know the origin of the method, but the principle underlying it is that the film of soap will help to prevent invasion by bacteria and at the same time help to dry the area. Other preparations that I have used are zinc oxide and castor oil, zinc oxide and alcohol, or balsam of Peru.

May I add in closing, a remark made on this subject by a doctor? "Nurses are on the verge of wasting their time if 'special back care' doesn't include a good massage to the area."

FAY BEEK, New Brunswick

Dear Editor:

Thank you so much for my copy of the October issue of *The Canadian Nurse.*

I feel very proud to have had an opportunity for my articles to be included in your magazine. I feel especially privileged to appear in the same issue with such distingushed persons as Helen Mussallem and Sister Lefebvre.

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VOLUME 56 NUMBER 12

MONTREAL, DECEMBER 1960

NOTHING UNCERTAIN

THERE IS A LEGEND that Confucius once was asked by a disciple what he would do first if it were left to him to administer a country. Confucius replied: "It would certainly be to correct language." His listeners were astonished. "Surely," said they, "this has nothing to do with administration! Why should language be corrected?" The Master gave a typically Chinese response:

> *If language is not correct, then what is said is not what is meant; if what is said is not what is meant, then what ought to be done is left undone; if what ought to be done remains undone, morals and arts will deteriorate, justice will go astray, the people will stand about in helpless confusion. There must be nothing uncertain in what is said. This matters above everything!*

One hundred years ago, the heroic venture of the opening of the Nightingale Training School at St. Thomas's Hospital, London, established a pattern of nurse education that reached out to every continent. For nearly half of that century, Florence Nightingale participated in the wider field of public health and education through her voluminous correspondence and other writings. Acutely aware of the importance of making herself clearly understood, Miss Nightingale expressed herself forcefully. There was "nothing uncertain" in her approach to any problem.

Over the years since 1860, leaders in nursing in many lands have explored innumerable facets of nursing education and service. They too have spoken and written in a language that meant what was said. Our most recent example of this clear, forceful language is to be found in Helen Mussallem's Report of the Pilot Project on the Evaluation of Schools of Nursing in Canada. The approval by the convention body of the recommendations included in the Report has already set in motion some chain reactions that reveal a definite need for *every* nurse — not just the leaders — to be fully aware of the implications of the Report. They must strive to understand the need for the changes in the pattern of nursing education so that they may act as interpreters. How can every nurse acquire the necessary understanding? How can they become fluent in the correct language that will enable them to interpret nursing's goals?

Sir Winston Churchill pointed out the road that every nurse might follow when he explained that though he had little enough of formal education, he had "picked up some as he went along through his reading." While we cannot aspire to emulate Sir Winston's famous skill in speaking and writing, every nurse can become more fluent if she cultivates the habit of reading good literature.

Each good book is a little universe in itself. It should be savored, lived with, thought over, relished, and all of this unhurriedly. It is better to read one good book thoroughly than to skim through fifty. Such reading will improve both our mental processes and our vocabulary. We think with words. If our storehouse of words is limited, we cannot think with flexibility and depth. Our minds become "tongue-tied."

We should read a variety of material — professional books and journals, of course, but not to the exclusion of all others. With a good dictionary available in case of need, we should find delight in new ways of expressing old ideas. All the while we will be building our own language so that it is correct — so that we say what we mean — so that there is nothing uncertain in what we say.

M.E.K.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — DECEMBER, 1920)

Edith Cavell Memorial — On the fifth anniversary of the death of Edith Cavell, Princess Clementine of Belgium unveiled the memorial on the Thames Embankment, given by the people of Belgium to the British nation. It represents Belgium as a woman dressed in deep mourning telling her children that Belgium will never forget their debt of gratitude to Britain.

The anniversary was observed in London as a memorial day in aid of the Edith Cavell Home of Rest for Nurses. Many wreaths were laid at the foot of the statue in Charing Cross Road.

* * *

The Cause of Warm Autumn — The warm weather in October is said to be the result of the unusual alignment of the four planets — Jupiter, Uranus, Mars and Saturn. They were all in direct line with the earth for the first time in many centuries. The combined pull of these great bodies was considered certain to affect the earth's orbit. We might expect longer summers in the Northern Hemisphere and shorter in the Southern.

It is said that a device has been perfected for rendering collisions between trains impossible. During the trial a passenger train was run at full speed past signals which were set againts it, only to be pulled up at a given point by automatic agency. It is an electric brake device on the engine, which is set in motion by a short third rail laid down at intervals along the track.

* * *

It is a well-known fact that the recent war has brought forth conditions in the nation such as in normal time would never have been dreamed of: we have been taught the great value of cooperation as shown by the accomplishment of the Allied armies, and it is now up to us to apply this lesson of cooperation to other activities of life.

Perhaps nowhere has a greater change been wrought than that experienced in the field of medicine. Human life, formerly thrown ruthlessly into a garbage pile, has finally reached its correct evaluation and has come to be regarded as a thing which must be conserved and strenghtened at all costs.

Boxing Day, December 26th, is the day chosen by the English to dispense "boxed" largesse to tradespeople and servants.

Turkeys became popular at Christmas about 1573. Prior to this, wild boar was the choice for the festive table.

Planning for the Future of Education in Nursing

HELEN NAHM, A.B., M.S., PH.D.

An authoritative opinion on the problems of evaluation and accreditation.

AFTER HAVING READ the Report of the Pilot Project I am impressed — not only with the quality of the study itself, but also with the statesmanship exhibited in the recommendations for the future of nursing education in Canada. Each recommendation complements and supplements the others. In them you are saying, "It is time to take a realistic look at where we are in nursing education today, and then to see what immediate steps can be taken to improve the existing situation." At the same time you are saying "It is time also to look to the future, and to plan with courage and foresight to meet future needs."

Recommendation I — "That a re-examination and study of the whole field of nursing education be undertaken" is the most significant. As a first or preliminary step in re-examining and studying the whole field of nursing education, we need to look at the past and evaluate the effectiveness of the steps taken over a long period of years — steps that represent our continuing struggle to control our own destiny. William K. Selden in his recent book *Accreditation, A Struggle over Standards in Higher Education,* (p. 40) states that:

> . . . in all societies the struggle for control is ever-present, and in democratic societies the privilege of publicly expressing contention and disagreement is well guarded.

This history of nursing in Canada, the United States, Great Britain, and many other countries, clearly portrays the struggle of nurses to control their own educational programs and, in so doing, to protect the welfare of the patients for whom they are responsible. Accreditation is only one method of control. The development of nursing organizations, the sponsoring of licensing laws, the initiation of extensive studies, the development of nursing periodicals, the publishing of nursing textbooks, curriculum guides and manuals of various kinds, all represent efforts of nurses to control their own destiny. In planning for the future it would be wise to study the relative effectiveness of the methods we have used in the past, and to eliminate or change those whose outcomes have been less than was initially anticipated.

A Look at the Past

The Associated Alumnae of the United States and Canada, founded in 1896, and which eventually developed into the Canadian Nurses' Association and the American Nurses' Association, represented one of the first efforts of nurses to work together in solving their mutual problems. The sponsoring of licensure laws, which automatically made essential the setting up of minimum standards to be applied in evaluating educational programs that prepared nurses for licensure, followed the development of nursing organizations.

In the years following World War I, the period during which the inadequacies in nursing education programs were clearly highlighted, extensive studies of nursing and nursing education were inaugurated. The Goldmark Report, *Nursing and Nursing Education in the United States,* published in 1923, was the first. Studies made in the United States by the Committee on the Grading of Nursing Schools resulted in three reports, *Nurses, Patients and Pocketbooks,* published in 1928, *An Activity Analysis of Nursing,* and *Nursing Schools, Today and Tomorrow,* published in 1934. The *Weir Report,* published in 1931, represented an extensive study

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of nursing and nursing education in Canada, as did the *Lancet Report,* published in 1932, of nursing and nursing education in England.

All of these studies were made by highly competent individuals. Recommendations embodied in these reports were far-reaching yet, in retrospect, we must admit that they were not implemented to the extent necessary to bring about much-needed changes in nursing and nursing education. In attempting to determine why this was so, we need to question the basic assumption underlying the initiation of all of these studies:

> that if excellent studies are made by highly competent individuals and reports of these studies are published, the recommendations embodied in the reports can and will be implemented.

For the future, we need to formulate our plans in relation to a newer assumption — one that is being widely accepted in general education —

> that the extent to which desirable changes are actually brought about is directly related to the extent to which persons concerned about those changes are involved.

This means that nurses themselves, as well as others who have a stake in the future of nursing and nursing education, must have an active part in the initial planning and implementation of studies, as well as in carrying out recommendations which evolve.

Our failures of the past are also related to the fact that, in nursing, we have had inadequate concepts of responsibility, authority and power. Certainly, nurses themselves have the responsibility for defining their own field. Society, at least in theory, accords to each profession the authority essential to carry out this task and to develop standards necessary to protect the quality of education through which professionals are prepared. Too often, however, we nurses have tended to say "We alone have the answers, and we are right." We have then attempted to use force to bring about change. In the process we have overlooked the fact that other groups such as hospital administrators, the medical profession, educators and dissident groups in our own profession also think they have the answers — that they are right about what nursing is and how nursing students should be educated. These groups, too, have power and they may attempt to use force to get their own way. The only possible outcomes are either that one group will eventually win out over the others, or that several groups will join forces to defeat a group with which they disagree. The fact that nurses have not won many of the battles of the past is dramatically highlighted by the continuing weaknesses in nursing education and nursing service programs. In *Fundamentals of Administration for Schools of Nursing,* (pp. 12-13) it is pointed out that

> When different or conflicting interests of two or more persons meet, the method of adjustment may be any one of four types:
>
> 1. Voluntary submission of one side, in which the adjustment is in one direction only;
> 2. struggle and victory of one side over the other, in which the defeated are compelled to do the adjusting;
> 3. compromise, in which each side makes concessions until they meet somewhere along a scale of values;
> 4. integration, in which neither side makes concessions to the other, but the adjustment is achieved by a new synthesis which satisfies both. The latter method is described as both interactive and creative.

Planning for the Future

We must begin with the basic assumption that "nursing shares with other health professions the responsibility for assessing present and future health needs of people in this and other countries of the world, and for planning to meet these needs." If we accept this assumption we must attempt to determine what the health needs of people will be in the years to come and what it will be possible to provide. We then need to ask ourselves such questions as the following:

> 1. Who will our patients be? What kind of care will be needed by the chronically ill and aging, the mentally ill, the tuberculous, mothers and children, and many other groups? Are there other groups in our society who should be looked upon as sick — alcoholics, delinquents, criminals, and do we share, with other professions, the responsibility for their care?

2. Where will our patients be cared for? Will we continue to provide 24-hour care for the majority, or will there be an increased development of home care, outpatient, and day-night services? Will the character of general hospitals change as maximum and minimum care units and convalescent services are provided?

3. What will be the probable changes in medical practice? Will the highly prepared medical specialist pass on to the nurse many of the comforting and supporting functions formerly performed by the family physician? Will he delegate additional technical functions? If so, is the nurse the best prepared person to carry these out?

4. What will be the probable effects of these changes on nursing practice and the organization of nursing services?

5. What will be the probable effects of these changes on nursing education?

a) Is there a need for nurses to be prepared at more than one level? If so, what kinds of educational programs in nursing are needed? What changes should take place in existing programs?

What is the future role of collegiate nursing programs? Of diploma programs? Of vocational nursing programs? How should students be recruited and selected for the various types of educational programs in nursing?

b) How many and what kinds of nurses are needed for leadership positions and how should they be prepared? Should we attempt to prepare highly expert clinical practitioners in nursing? If we prepare them, will they be employed by nursing service agencies, and will they be given sufficient remuneration to compensate them for expending the time and effort necessary to become expert practitioners?

c) How much can be encompassed in a basic program in nursing education? How skilled do we expect a beginning practitioner to be?

d) What kinds of in-service and continuing education programs are needed to help employed nurses improve their own practice? Who should be responsible for the development and financing of such programs?

e) How can we prepare nurses for research in the nursing field?

6. How many and what kinds of nurses do we have at present? How well-prepared are they for the positions they hold? How well are they distributed? What are their ages, their marital status, their plans for the future?

The inevitable result of seeking answers to questions such as these, will be a clarification of goals for the nursing profession and the formulation of principles to be applied in planning action programs essential to the achievement of these goals. Too often in the past, opinions of strong individuals or groups have been vehemently stated. Too seldom have the basic principles underlying those opinions been clearly elucidated. Principles can be defended; they can be used to educate those who initially do not see things as we do. Opinions, on the other hand, are often difficult to defend, and are much more likely to divide than to unify groups. We must also assess the social, political and economic forces that have already brought about widespread changes in nursing and nursing education and that will continue to bring about changes in the years to come. We must take into account the human emotions that are aroused when widespread changes take place and anticipate the possible consequences of following one plan of action or another.

The Changing Role of the Nurse

Prior to World War II, when the word "nurse" was used, the picture that came to mind was of a graduate of a three-year hospital school program who gave direct care to sick patients. When the word "nurse" is used today the picture may reveal an aide trained on the job, a practical nurse, a graduate of a traditional diploma program or a graduate of a college or university program.

The professional nurse of the past took great pride in being a graduate of a distinguished hospital school of nursing. Present criticisms of hospital schools, coupled with the emphasis on the importance of collegiate education for the nurse who functions at a truly professional level, have upset old patterns of loyalties for many practising nurses. Anselm Strauss, in *Mirrors and Masks,* (p. 108) states that:

> When organizations and institutions are expanding, forming, disintegrating, or in any way changing radically, the personal lives of their members are rendered more tortuous and uncertain and, at times, more dangerous and exciting; such changes dog not only the old-timer, but also the novice who blindly follows old career patterns.

He talks about the importance of identification to the individual. When we ask a person to turn his back on the past and dis-identify himself with old practices and to question certain important "me's," for a time, he is midstream between danger and discovery. To survive, he must regain his world and must develop new concepts about what is worth striving for and fighting for. "To be deeply involved in a course of action is *to care, to be concerned, to be identified* with it."

The professional nurse of the past took great pride in giving high quality bedside nursing care. In the majority of hospitals today much of the direct personal care is given by practical nurses and aides. The professional nurse performs technical, administrative and supervisory functions but her role is not clearly defined. She faces pressures from administrative personnel to assume administrative and supervisory functions for which she usually is not prepared. At the same time, she is pressured by physicians and patients to assume traditional care roles that the work situation often makes impossible.

Alan Treloar and Don Chill, in a recent article in *Hospitals* (32:42), define nursing as "a multifaceted, paraphysician service and . . . the fact that it is multifaceted, rather than unifaceted, is the major reason for the dilemmas the nursing profession faces." We ask nurses today, particularly those in responsible positions, to plan, to administer, to teach, to supervise, to study, to read, to think, to communicate, to understand, to evaluate and to do research. This is a large order, even for the young, the highly motivated and the well prepared.

The Effect of Change

Not only must the reactions and feelings of nurses themselves be anticipated in planning action programs for the future, but also reactions and feelings of others who will be affected, either directly or indirectly, by changes which take place. When changes are made in educational programs in nursing, administrators and boards of trustees of hospitals that conduct schools of nursing, doctors, and patients and their families will be directly affected. Administrators in colleges and universities that conduct collegiate nursing programs are also likely to be concerned. Hospitals and other agencies that employ nurses, but do not themselves conduct educational programs, are affected indirectly. Any movement that has a direct effect on the public welfare is likely to create concern on the part of many groups within a society, even though these groups are not directly affected.

Nurse leaders of the past have certainly had justifiable reasons for concern about the quality of educational programs in nursing. In their zeal to bring about change they have often taken insufficient time to educate the groups likely to be affected by changes. As a result, the methods used came to be regarded as revolutionary rather than evolutionary.

> As an example: An extensive study was made in 1949 in the United States by the Sub-Committee on School Data Analysis of the National Committee on the Improvement of Nursing Services. Following the study, the *Interim Classification of Schools of Nursing* was published, with the upper 25 per cent of schools classified as Group I schools and the middle 50 per cent as Group II schools. The lowest 25 per cent, the Group III schools, were not listed. When the Interim Classification was published the schools of nursing were promised that a follow-up study would be made within two years. The National Nursing Accrediting Service was asked to accept responsibility for the second study. Instead of a second listing it was agreed that a program of temporary accreditation would be developed.
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> Hospital and nursing service administrators, boards of trustees of hospitals, medical associations, both state and national, administrators of colleges and universities, and many other groups reacted quite antagonistically in many instances, to both the Interim Classification of Schools of Nursing and the Program of Temporary Accreditation.

Yet, when efforts were made by the staff of the National League for Nursing and nurse leaders associated with various types of educational programs in nursing to meet with dissident groups and to include them in future planning, attitudes of the groups usually underwent marked changes. Many persons who initially came to criticize, remained to help implement what soon came to be known as a nation-wide program to improve schools of nursing. Perhaps, if more time had been taken initially to gain the support and understanding of all concerned groups, the program of school improvement might have moved along at a more rapid pace, with far less trauma to the schools of nursing themselves and to all persons affected by changes in the schools.

To look into the future of nursing and to plan realistically to meet future nursing needs is a formidable task. Its success will be directly related, not only to the clarity of the goals, but also to the methods used to achieve them.

Planning for Accreditation and School and Service Improvements

Though I have focused primarily on implementation of Recommendation I, there are factors to be considered in implementing Recommendations 2, 3 and 4. The difficulty of initiating a school improvement program and an accreditation program, without at the same time initiating a program to evaluate the quality of nursing service in those areas where students receive their clinical experience, is recognized in the recommendations. This is most important. Although educational programs exist, essentially, to prepare students for future service, there is a direct relationship between the quality of nursing care which students observe and the effectiveness of their educational program.

Many changes have occurred in both the philosophy of accreditation in higher education and the procedures that are developed. The procedures now being recommended by some accrediting agencies in the U.S. focus heavily on the need for improvements in educational programs. An educational program should be judged in terms of the purposes it serves. The function of an accrediting agency is to stimulate self-study and self-evaluation. This is in direct contrast to the old procedures which focused on highly specific and largely quantitative standards.

Many problems associated with accreditation have not yet been solved. These may be summarized as follows:

1. Institutions continue to be confronted with many criteria and voluminous questionnaires. Yet, few criteria have been verified to ascertain their reliability in distinguishing good from poor institutions. No method has been found of determining the merit of an institution in relation to either what happens to students during their period of enrolment or to their effectiveness following graduation.
2. Survey visitors and reviewing groups still carry heavy responsibility — not only for sound decisions, but also for constructive and unbiased suggestions.
3. The relationships between professional accrediting agencies and state licensing boards (in the U.S.) have not yet been clarified.
4. In collegiate schools of nursing the extent to which the college or university accepts responsibility for professional education directly affects the quality of such education.
5. There is potential conflict between the focus on self-study and self-evaluation, and evaluation by others. Accreditation, ultimately, represents evaluation by persons from the outside. The less able a school is to evaluate its own program, the more it tends to look upon evaluation by others as a threat.
6. The extent to which survey visitors can be objective is related to their own training and experience.
7. Strong schools may benefit little from the accreditation process; yet, unless they are willing to participate in an accreditation program and to help weaker schools, the entire process of accreditation will be ineffective.
8. It is difficult to decide how frequently resurveys should be made, and how comprehensive they should be, particularly where strong schools are concerned.
9. The costs of accreditation continue to be high. Unless some method of spreading the costs can be found, they will continue to be inordinately high for the individual school.

A number of critical problems associated with accreditation are pointed out by William K. Selden in *Accreditation, A Struggle over Standards in Higher Education.* Among these are the following:

> 1. The opposition encountered from persons whose previous education is threatened by implication,
>
> 2. the opposition encountered from individuals who operate schools with low standards; if operated for profit, criticism of them creates an immediate economic threat to their owners,
>
> 3. the relationship between the emphasis on the importance of professional accreditation and the desires of individuals to attain a high vocational status.

In discussing the latter item Selden makes the following statement:

> Not only do they (professional associations) aim to create an organization which will foster research, advance learning in the profession and improve service to the public, but they develop an impelling motive to raise individual status by restricting admission to the profession — sometimes with more emphasis on the interests of practitioners than on the public welfare.

Though pointing out the many inherent difficulties in the accreditation process, Selden also emphasizes its values. In a recent article entitled *Why Accreditation* he states that even though no subject seems to elicit such a variety of responses from educators, many of which indicate a lack of previous and accurate information, the overall values of accreditation have been great. These values are summarized in the following statements:

> The influence of accreditation and the potential threat of disaccreditation have served as a countervailing force in situations where influences, both external and internal, could have conceivably subverted a college or university from its rightful purpose.
>
> I insist that accrediting is a manifestation in education of our form of civil government and political control, and as such, it is an integral and irrevocable part of the structure of higher education in this country. But I equally insist that just as we must exercise greater inspiration in realigning some of the various government procedures and responsibilities to care for the immense growth in population and the rapid technological and social changes, in the same way we must submerge local pride and selfish interests and must use imagination in revitalizing accreditation so that it is more of a constructive than a standardizing force in education.

Educators who continue to be concerned about improving accrediting procedures emphasize the need to recognize differences among schools — differences in purposes and objectives and in admission and retention policies. Norman Burns, Secretary, North Central Association of Schools and Colleges, recommends that:

> institutions publish more accurate descriptions of what they do, what admission requirements they set, what kind of students they wish to educate, what becomes of their students after graduation, and what significant differences there are between the highly selective and the less selective.

He feels that fuller information about institutions would have great public value and would help prevent invidious comparisons.

In implementing the Pilot Project recommendations that there be simultaneous development of accreditation and school improvement programs, Canadians will profit from the experiences of both general and professional accrediting agencies in higher education and, in so doing, build a constructive and positive, rather than a standardizing program. Through a school improvement program, early contact can be made with schools of nursing to provide guidance and to become familiar with their problems. An association over a period of time will help many to make the changes that are essential in meeting criteria for accreditation. As your program develops perhaps you can publish the kind of descriptive list recommended by Dr. Burns, rather than the kind of list that merely states that an institution is accredited.

In closing, a statement made recently by Robert Gordon Sproul, President Emeritus of the University of California, seems appropriate:

> There are times when institutions, like individuals, must pull themselves up by their own bootstraps, and the present era of widespread reappraisal of educational values would seem to be one of these times.

The Patient Returns to the Community

Isobel MacLeod, M.A.

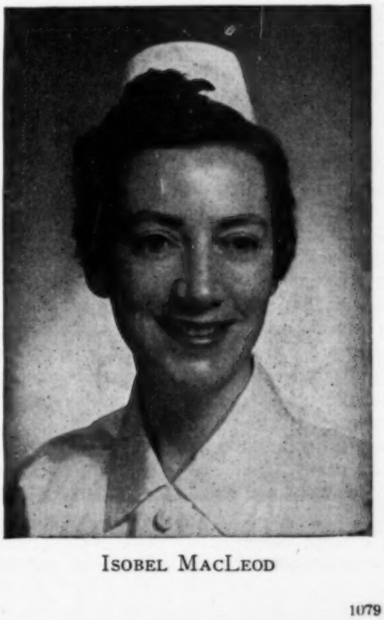
Total patient care requires the cooperation of many disciplines. Good human relationships are a prerequisite to such cooperation.

For many years we, in nursing, have recognized that we must think of our patient in his total environment; that there is always an emotional and social aspect to his illness and its cure. This has made it necessary for us to plan from the beginning of his hospitalization for continuation of the nursing care that he will need after he has returned home. It makes it necessary, too, to include the patient himself, his family and other professional workers when we are planning total care. We are presently concerned with the problem of how we may function most effectively in promoting this coordination of effort in order to bring about the maximum rehabilitation of our patients.

Organized hospital home care plans are a recently developed channel to promote coordinated effort between workers, both inside and outside the hospital, with those individuals who are most important of all in the patient's final rehabilitation — the members of his family. Because we know that the patient benefits from human relationships, we recognize that often his home is the place where he can receive the greatest measure of supportive care. This is especially true in the care of children, of the elderly, and of long-term patients. Caring for the sick at home presents many problems. The family will need help from a number of agencies, including the hospital. Rather slowly, hospitals are beginning to provide the necessary comprehensive services. It is to their credit that nurses, of their own initiative, made a beginning in this direction by establishing liaison programs between certain hospitals and Victorian Order nurses in order to provide continuity in nursing care.

The Role of the Family

Sometimes, for a variety of reasons, a patient cannot be cared for adequately at home throughout the entire course of his illness. In such instances, we should endeavor to transfer the healing aspects of the home to the hospital as a definite part of therapy. This has been done successfully in the more advanced pediatric institutions. The parents are encouraged to be present and to take an active part in the care of the child. The problem in adult general wards, however, is more difficult to solve. Some hospitals have gone the full way and have permitted unrestricted visiting. Others have been more conservative. The fatiguing effect of large numbers of relatives and friends constantly at the patient's bedside has been observed. Visitors in quantity demand a kind of social interaction that the sick are frequently not capable of providing without damaging strain. Is there not a responsibility on the part of hospital authorities



Isobel MacLeod

Mrs. MacLeod who is director of nursing, Montreal General Hospital, presented this paper at the CNA biennial meeting in June.

to make better use of family members when they do visit? Perhaps visitors should be limited to a stated number and should be people whom the patient really wants. After he has told his doctor or nurse in confidence whom he wishes to see, should not these persons be permitted very generous visiting privileges? Surely it is then the responsibility of those caring for the patient to take from him the burden of less welcome visitors. This responsibility would require the utmost skill, kindness and good will. The chosen visitors should be encouraged because they can give comfort to the patient and they can become helpful members of the therapeutic team.

Team Conferences

Another channel through which we can promote coordinated follow-through from hospital to home is the regular planned conferences of all the workers concerned in the care of a patient from the very beginning of his hospitalization. These should be instituted and continued until we are sure that the patient has reached his maximum rehabilitation. Such conferences are coming into popular practice, especially for the long-term patient who has special problems. They bring together hospital and community workers with special skills. They include physiotherapists, dietitians, occupational therapists, social workers, occupational nurses and others. It is essential to ensure that meetings are called only when they can be useful. Most of us have attended gatherings where mutually helpful relationships failed to be established and we have regretted the time wasted. But this should not deter us from striving to overcome the professional isolation in which the various groups of the health services all too frequently work. We should discipline ourselves to hold at least one such comprehensive planning conference for virtually every patient. The minimum composition of this group should be the doctor, the nurse, the patient, and at least one member of the family. Of course, modifications may be necessary. At times, the patient may not be able to participate even in a brief consultation at his bedside, but usually he will be able to participate eventually. The "family" in some instances may not be an actual relative. However, if there is anyone in the patient's life who will be meaningful and helpful to him after discharge, that person should be included in the planning.

It may not always be possible to have every member of this team present at every conference. It may not even be possible, regrettably, to have everyone together at any one time but it does seem that communication among these four basic people is essential, if a workable plan for rehabilitation is to be developed. It also seems that the person in the best position to ensure successful communication between all concerned is the nurse. Many times it can challenge the best that we can give in intellect, skill in human relations, patience, compassion, and understanding. I believe that if this coming together were considered by doctors and nurses as a required part of every patient's cure, and as a procedure that it would be unthinkable to omit, we would see dramatic changes in patient recovery, in family unity and in personal satisfactions on the part of those in attendance.

I am aware that many people say, when this is mentioned, "But we *do* have this communication." I know that we do *sometimes*, but do we not betray our lack of understanding of the place of such communication as an essential part of the healing process when we do not provide it systematically for all patients?

It has been mentioned that all too often our conferences fail to establish the degree and kind of communication that is necessary for the effective working of a health team. The whole success of any means that we may devise to coordinate our efforts to return the patient to his normal environment depends upon our ability as professional people to work constructively as partners. It is essential to have the desire and the sensitivity to feel what another is feeling; to be able to give ideas and to question ideas in an acceptable way; to contribute, so that others are strengthened in understanding and in self-esteem; in short, to become a part of a working group from which the members emerge with more knowledge, more confidence, more inspiration, more respect for themselves and others. This is health as applied to working relationships. It is what we want to achieve in order to provide the best for our patients. In order to do so, we need an abundance of this kind of health ourselves. Perhaps this is something that we, who practise the healing professions, should pursue more consciously. Our concern as nurses is to be sure that the experiences we create for one another, as we practise and as we educate student nurses, promotes this broad aspect of health. We have to place more emphasis on the development of working relationships which are, in themselves, abundantly fulfilling.

Does the experience of the general staff nurse in the hospital do all that can be expected to develop enjoyment from giving direct patient care? Does it stimulate a desire for more knowledge and skill? Does it promote enthusiasm and self-esteem? Does she receive from those around her the feeling of status that the expert practice of bedside nursing should give?

Many of us feel that more should be done to give the general staff nurse the satisfaction she deserves and must have before she can give fully to her patients and co-workers. Nurses are treated, for the most part, with justice and courtesy. Personnel policies are usually fair. This is not enough! What else can be included? Beginning with the arrival of the new nurse, we can take steps to ensure that her reception, her orientation program and later her participation in an in-service educational program and staff association activities will be such as to give her a feeling of status, respect and partnership in a strong, cohesive, working team. I am sure many of you could add other and better ways.

There is one factor above all others that is of paramount importance. If it is good, it can offset weaknesses elsewhere. If it is poor, other influences will not compensate. It is the day-to-day working relationships on the ward. The leadership skill of the head nurse in promoting work satisfaction by requiring a high standard of patient care along with the promotion of a high standard of staff morale is what we are most dependent upon here.

To sum up it might be stated again that the great barrier to effective functioning is working in isolation. This might seem like an over-simplification, but the contrary is true. Even among a staff of 18 or 20 on a single unit, the nurses can be isolated psychologically from one another. They may meet daily for reports and team conferences. Sometimes a head nurse can bring to these meetings ways of promoting rich relationships. On the other hand, she may find that other conferences are necessary to bring into the open both dissatisfactions and ideas for improvement. So often I have seen poor relationships perpetuated because people are not brought together by someone with the skill to promote constructive communication. We have to keep in mind, too, that none of us can do our best work when we are too isolated. We need adequate communication with others who are struggling with the same problems. Regular meetings of small groups of head nurses are essential, if they are to obtain the release of tension and the stimulating companionship that will enable them to give generously to their staff. How to make these conferences meaningful would take a book. Indeed, books have been written on the subject. I do believe though that if even the first step is taken and isolation is overcome by bringing people together constantly and regularly, with goodwill, in time a creative process will develop.

What of student education? Surely, the same needs are seen here. We have added much to the curriculum in the way of psychology, human relationships, sociology, human development. We carry this over quite well in clinical teaching through practical applications in meeting individual patient needs. The need is not for more teaching, but for more experience in working together effectively. While we teach much about human relationships in our schools of nursing, many of you will agree that what is taught in theory is not necessarily translated into practice. Sometimes, those who can quote the theory best have a great deal of difficulty when it comes to practice. Thinking back to the necessity to produce nurses who can work with other professional workers to promote the patient's return to the community, it seems that the provision of opportunities for students to experience satisfying relationships should be an essential part of the curriculum from the day they enter the school until the day they graduate. To promote the qualities and skills needed by nurses for the future, we will be required to use all of our ingenuity in finding varieties of ways for them to experience democratic relationships among themselves and with others in small groups in solving mutual problems. These problems may be ones of group living in residence, which are dealt with by means of the student association and student government. They may be problems of patient care on the ward. Students require the guidance of teachers and administrators who can help them develop the skills of identifying with another's viewpoint; feeling and accepting another's feelings; coping with anger and mending relationships after conflict; and especially in receiving pleasure and satisfaction from working with others.

Soliloquy of a Purchasing Agent

Arnold Sharpe

Purchasing hospital stores entails much more than an order pad and pencil.

WHO AM I? What am I doing wedged for hours within four walls? Vendors! Catalogues! Directories! Price trends! Commercial registers! These hum through my head in a dizzy tune. I glance at the door and read my title through the glazed pane: **"tnegA gnisahcruP"** — an apt symbol of just how I feel after dismissing the 11th salesman since eleven o'clock. But the 11 salesmen could not have read what I am reading or they would not have had the heart to knock at my door. Of course not! They read it from the outside, and to them it spells hope. I stand for their bread and butter. Purchasing Agent! An agent — one who acts for another. The sudden awakening to consciousness of whom I am acting for pulls me up from any weary slump and directs my glance to my memos for tomorrow.

9:00 A.M. See the supervisor of Central Supply about chest suction. Oh, yes! She wants some new-fangled apparatus that she probably saw on exhibition at the convention. I wonder why people can't be satisfied with something that already does a good job, without getting all excited about everything new that comes along? Moreover, how can it possibly benefit the supervisor to get new equipment? She hasn't enough space for her equipment now. There must be something behind this. Better patient care? Perhaps. We'll talk it over.

9:30 A.M. See storekeeper re: anesthetic supplies. Check on new helper. I'm sure he's what we want. It might encourage him to have me drop in and ask how he's getting along. I must stop off at the print-shop to see what's holding up the work on the storeroom catalogues.

10:00 A.M. Agent from suture company. I wonder how he'll handle the complaints about the needles! I was *sure* I had snatched the best offer. There are so many things one has to keep in mind. It's hard when you're bombarded with clever sales talk.

11:00 A.M. Salesman for acid proof, flame resistant, waterproof, washable mattresses. I mustn't keep him waiting as I did the last time he came! I have to keep reminding myself that time is valuable to those fellows too. Besides, we need them. It would be pretty hard to be selective enough if we had to race around to all those firms to test quality.

1:00 P.M. Staff meeting — hospital auditorium. Here's hoping I can clear up once and for all this annoying business of half completed requisitions. Administration asked me to highlight the new procedure manual. That should work in without getting me

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Mr. Sharpe is purchasing agent at St. Mary's Hospital. Montreal.

labelled "Crank No. 1!"

2:15 P.M. Salesman from — no, that's cancelled! One precious hour to think and plan. We simply *have* to cut down costs or I'm not worth my salary. It isn't right for room rates to be raised to offset the mistakes of management. This is the place we can save the dollars without antagonizing the personnel and upsetting morale. It's a good chance to boost morale with our "economy of effort program."

3:30 P.M. Visit to laundry equipment firm to wind up the day. They have good extractors, I'm told. Three hospitals in the city are using them with satisfactory results.

Speaking of laundry, I must get the hospital supervisors together and let them in on my little research project. I'll prove to them how we can save money by standardizing our detergents and still have everything just as clean as ever. Why eight women have to have eight different ideas about what is best in detergents is beyond me! I suppose I *could* blame T.V. but that wouldn't simplify the problem.

Well, if I don't leave now I'll be late for the big dinner and demonstration of the respirator. I wouldn't miss that for anything. Come to think of it, a patient's life might depend on whether or not we purchase that equipment. If we rent it, they have to wait for it to arrive. While they wait, they have to pay. You just can't get away from it. It is the patient who benefits when we buy wisely. To buy or not to buy, that is the question.

PURCHASING - STORES

Sister Mary Assumpta, B.Sc.

The basic purpose of any hospital is to provide the best possible service at the lowest possible cost.

In order to carry out its basic purpose, as many as 22 separate departments may be called into play in a hospital. The Purchasing Department is one of the most important. It is a *staff* department, in an organizational sense, in that its services are available to all other departments of the hospital, but it does not exercise any direct line control or authority over other departments. This department must handle its work in such a manner as:

1. To effect purchase of high quality hospital supplies at the most favorable cost;
2. to ensure an adequate supply of the required kinds of materials and supplies in order to maintain the most efficient level of operation and meet the demand of all departments.

There are various means of accomplishing this through proper and adequate purchasing policies. One such policy is centralization of authority in one purchasing office, as is our practice at this hospital, with the exception of pharmaceuticals.

By centralized purchasing, we understand that the procurement of all purchased materials and supplies is concentrated in or channeled through a single department, under the direction of one responsible person. The more centralized the authority of purchasing, the greater the interdepartmental responsibility. An important reason for a centralized system of purchasing is that it acts as a timesaver for our department supervisors. We can direct our full attention to the operation of our departments since we are relieved of the obligation of interviewing sales representatives. This is the responsibility of our purchasing agent, in whom we have placed our confidence. On occasion, at the discretion of the purchasing agent, a department head may be invited to the purchasing department to consult with an agent in order to obtain information or to supply it.

Sister Assumpta is supervisor of the obstetrical department, St. Mary's Hospital, Montreal.

————————Hospital

Serial No.

Place	X	Daily		Store	Printshop
Opposite	Designations	Weekly	**Requisition on**	Pharmacy	Dietary
Desired		Purchase		Maint'nce	Laundry

For use in	Dept.	Charge to Account No.	Date	19

Instructions: Requisitions should be written neatly and clearly. All items should be described exactly by Code, Catalogue No. or size. Weekly requisitions must be approved by Department Head before delivery to Purchasing Office. Put only stock items from the same grouping on this requisition when drawn on the storeroom.

Please	Repair Deliver the following	In: To:	Do not write beyond this line

On Hand	No. Wanted	Unit	Catalogue No.	Name of article or repair requested and full description	Amt. Issued	Unit Price	Extended price	Store-keeper Remarks

To be purchased from	Requested by
	Approved by
Date Order No.	Approved by
Purchase approved by	Filled by
.... *Administrator*	Received by

Requisitioning

Our requisition form is used effectively for every type of repair, supply and purchase needed by any department. When it is a matter of repairs, the form is filled out, signed by the supervisor of the unit and sent to the nursing service and purchasing offices. When approved by the administrator, the requisition is forwarded to the chief engineer of our maintenance department.

If the repair is effected by hospital staff, the person who made out the requisition originally signs it after the work has been completed satisfactorily.

If the repair is to be made by non-hospital staff, the purchasing agent forwards the receiving copies of the purchase order to the department requesting service. Both of these must be signed by the original signee and returned to the purchasing office when the work has been satisfactorily completed.

Spaces are provided on the form for the date, the department, description of supplies, quantity ordered and quantity delivered so that, in the event of stock shortages, a back order may be written for delivery of the balance as stocks become available. Proper signature spaces are provided for the individual initiating the requisition and the persons approving the request. Space is also provided for the signature of the storekeeper and finally for the individual who actually receives the goods.

Requisitioning does not always lead directly to a purchase. It may result merely in the sending of a requisition to the Stores Department, where the need can frequently be met. A looseleaf storeroom catalogue indicates the supplies that are kept in stock. This catalogue, adequately planned and properly maintained, tends to promote both uniformity of description and uniformity of purchase.

All items in the storeroom are classified under eight control groupings:

Group 1. Glassware, china, cutlery, metal smallwares excluding soap and paper towel dispensers and containers.

Group 2. Housekeeping: Soap, toilet tissue, cleaners, wax, floor brushes, tray covers, paper towels and cups, napkins, mops.

Group 3. Laboratory: All supplies associated with laboratory work — slides, test and culture tubes, pipettes, I.V. apparatus including I.V. sets.

Group 4. Medical and surgical: Syringes, catheters, dressings, plasters, razor blades, creams, etc.

Group 5. Office supplies and stationery, all forms.

Group 6. Textiles: All finished and unfinished goods, uniforms, aprons, sheets, rubber and cloth sheeting, etc.

Group 7. X-ray supplies: Films, developer, fixer etc.

Group 8. Dietary: Canned, dried and non-perishable food stuffs.

When ordering stock items, we list only items from one group on any one page of the requisition. This is absolutely essential for inventory control and pricing.

Monday is the day assigned for completing requisitions to be sent to the storeroom. A "want" slip is clipped to the front of the storeroom catalogue on which supplies, that have reached reorder point, are recorded from day to day. Then it is just a matter of spot checking other requirements from the storeroom to make provision for the next week's demands.

The responsibility for ordering is given to the supervisor of the unit. The task of making out the requisition is, actually, performed by our trained ward secretary. The supervisor checks and signs the requisitions before they are sent to the nursing service department for approval. All requisitions for the week's delivery must be in the purchasing office by Tuesday noon of each week. There they are numbered, then examined, relayed to the administrator for approval and forwarded by Tuesday night for disbursement. Delivery of goods is made on Thursday and Friday. Orders are honored only when submitted on the proper requisition and when signed by a specifically authorized person. All requisitions are subject to administrative approval, except in the case of emergency.

The original requisition is returned with the supplies when the storeroom clerk delivers them to the unit. The person who originally requested the articles must personally receive and check the items and sign for those received in the space provided. The requisition is retained by the stores clerk so that the goods may be charged to the specific department. If an item is not in stock, the requisition is appropriately marked "Back Order" in the "Storekeeper's Remarks" column. Delivery is made as soon as stocks are available.

Defective or incorrect merchandise is returned to the storeroom immediately on discovery, together with a requisition form stating the quantity, description, etc. and the reason why the items are being returned.

Purchase Orders

Requisitions are routed through the office of the purchasing agent to ensure conformity with general purchasing procedures. The serial and purchase order numbers are provided by the purchasing department and do not concern the requisitioner. We find it a good practice to make a copy of the requisition. The copy is retained on file in the department. The original is forwarded to the purchasing office.

Department heads consult with the purchasing agent periodically and convey their intimate knowledge of products used in their departments. This acts as a guide to further buying. The purchasing agent acts or serves as a middle man between the using department and the various sources of supply.

Any new item is always investigated and the opinions of the personnel respected and considered when purchasing is to be done. Suppliers qualified to furnish a particular item are requested to submit prices and other data consistent with the hospital's needs. Upon receipt of quotations, the purchasing agent takes all things into consideration and buying is done on a bid basis.

In many cases involving requisitions for new equipment or replacement of old equipment, the request is referred to the administrator of the hospital for approval as is the case with stores requisitions. Such items may have a direct effect on the operating budget.

The budget is no more, nor less, than another administration tool. It simply points the way for those who must make decisions. The primary purpose of hospital budgeting is to forecast future financial planning. A purchasing budget is a very necessary adjunct to hospital administration. It should be flexible enough to allow for emergencies within a reasonable scope. Changes in circumstances may allow re-evaluation of needs that will effect savings.

In conclusion, since the purchasing agent administers and directs a program to purchase supplies, equipment and services, he contributes daily to the care of the patients. This makes him, as surely as the doctor and the nurse, a member of the hospital team.

Our Nurses Plan Their Time

Rita M. Ball

Careful planning of nurses' time results in meeting the nursing care needs of patients and the leisure-time needs of nurses.

Nurses who have worked a 12-hour day with two or three hours off will remember that this off-duty time was frequently of little benefit to them. How often it was used for sleeping because it was too short to be spent in other activities and occurred at an inopportune time of the day or night!

With the advent of the 40-hour week and three shifts, the question of planning hours off no longer exists in most institutions — but what of days off? These can be planned in such a way that the staff knows well in advance, the periods that they will be working and the days that they will be free. They can then plan their leisure time with the assurance that they will not have to change their plans to meet nursing service needs.

Establishing a Pattern

The first step in planning is the setting up of a staffing pattern. A pattern such as the following can be adapted to most staff set-ups. The sample rotation plan shows the pattern for each nurse. This pattern is repeated over and over. Each nurse on the unit works the same pattern. In order to provide a coverage of five nurses in each 24-hour period, each nurse is at a different point in the pattern on any one day.

Features of the Plan

Charge nurses are not included as they work 7-3 Monday to Friday, with Saturday and Sunday off.

The plan permits posting of a rotation pattern for three or four months or longer, since nothing is allowed to interfere. When a nurse leaves the staff, her shifts are filled in as needed by relief staff until a new nurse arrives. She is then given the vacancy in the pattern without altering the rotation.

The 10 statutory holidays are planned individually and may be arranged before or after days off, excepting

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Miss Ball is director of nurses at the Trail-Tadanac Hospital, Trail, British Columbia.

those adjacent to the 11-7 shift. Nurses who can only work on a part-time basis, relieve on holidays so that the shift pattern is not disturbed.

Night duty periods start on Friday so that the four days off following this period always occur over a weekend. It also works out that the second period of four days off includes Saturday and Sunday. (following the second shift of 7-3)

Advantages of the Plan

1. It is not necessary to follow this particular pattern of seven periods of duty between days off. The nurses may prefer to work a pattern of 10 periods on duty and 4 days off, for all shifts.
2. In any pattern each nurse can plan her time, all are treated alike, i.e. all have an equal number of week-ends.
3. The person directing the pattern can see in advance exactly where, when and for how long relief is needed.
4. The nurses who do part-time work can arrange to come in because it is possible to tell them in advance whether their services will be needed for one period of duty or seven.
5. The charge nurse is not required to make out a time sheet. The rotation patterns are made up in the nursing office and are alike for each unit.
6. A regular pattern helps to encourage good staff relationships. Each nurse can see the rotation of others on the staff and knows that all are being given equal advantages.

When nursing staff is kept at a minimum level it is necessary to have a sizeable list of nurses on call for relief. In this way, staff nurses are kept in their own departments. This is to their satisfaction. It also enables the person who is responsible for staffing to know exactly when and on what period of duty extra help may be necessary.

The plan has been so satisfactory for nursing staff in this hospital that it has been adapted for use in planning time for the nursing aides, orderlies, janitors and janitresses. The patterns are not identical but the principles are the same.

The staff is happier and more willing when their time off is planned with their interests considered as well as the welfare of the patients.

SAMPLE ROTATION PATTERN

Date:—																																																							
Day of Week:—	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Charge Nurse:—	7	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7	7	7	7	—	—
Gen. Duty #1	3	3	—	—	11	11	11	11	11	11	11	—	—	—	—	3	3	3	3	3	3	3	—	—	7	7	7	7	7	7	7	—	—	7	7	7	7	7	7	7	—	—	—	—	3	3	3	3	3	3	3	—	—	11	11	11
2	—	—	3	3	3	3	3	3	3	—	—	11	11	11	11	11	11	11	—	—	—	—	3	3	3	3	3	3	3	—	—	7	7	7	7	7	7	7	—	—	7	7	7	7	7	7	7	—	—	—	—	3	3	3	3	3
3	7	7	7	7	7	—	—	—	—	3	3	3	3	3	3	3	—	—	11	11	11	11	11	11	11	—	—	—	—	3	3	3	3	3	3	3	—	—	7	7	7	7	7	7	7	—	—	7	7	7	7	7	7	7	—	—
4	7	7	7	—	—	7	7	7	7	7	7	7	—	—	—	—	3	3	3	3	3	3	3	—	—	11	11	11	11	11	11	11	—	—	—	—	3	3	3	3	3	3	3	—	—	7	7	7	7	7	7	7	—	—	7	7
5	3	—	—	7	7	7	7	7	7	7	—	—	7	7	7	7	7	7	7	—	—	—	—	3	3	3	3	3	3	3	—	—	11	11	11	11	11	11	11	—	—	—	—	3	3	3	3	3	3	3	—	—	7	7	7	7
6	—	3	3	3	3	3	3	3	—	—	7	7	7	7	7	7	7	—	—	7	7	7	7	7	7	7	—	—	—	—	3	3	3	3	3	3	3	—	—	11	11	11	11	11	11	11	—	—	—	—	3	3	3	3	3	3
7	11	11	11	11	—	—	—	—	3	3	3	3	3	3	3	—	—	7	7	7	7	7	7	7	—	—	7	7	7	7	7	7	7	—	—	—	—	3	3	3	3	3	3	3	—	—	11	11	11	11	11	11	11	—	—	—

25 BED UNIT

7—3 shift on Saturday and Sunday short staffed.
Relief help called in where and when needed.
Statutory Holidays taken on 7—3 or 3—11 shifts only.

NURSING across the NATION

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Season's Greetings

National Office staff joins in extending greetings to nurses everywhere for a holy and joyful Christmas season. A Merry Christmas to one and all.

Canadian Conference on Children

Pearl Stiver, our General Secretary, attended the Canadian Conference on Children which was held in St. Adele, P.Q. October 2-6. Miss Stiver presented a statement outlining the activities of nurses in the health, welfare and educational programs for children and youth. The CNA emphasized the comprehensive nature of nursing care and the availability of the nurse; pleaded for better utilization of nursing services in the interests of child care; asked for support of nursing education and nursing research programs which will ensure nursing services of high calibre in all aspects of child care; and stressed the need for a broader understanding of the contribution of the nurse, who by the very nature of her work touches all facets of child care.

ICN Congress

To attend an ICN Congress is a never-to-be forgotten experience. This is an opportunity which is ours only once every four years. The ICN's Twelfth Quadrennial Congress in Melbourne promises to be the biggest nursing Congress ever to be held in the Pacific area. Nurses from all parts of Canada have registered and will be making their way by ship or by air to Australia. It is not too late to register. Nurses planning to attend the Congress should apply for Application Forms to the CNA National office, 74 Stanley Avenue, Ottawa 2, Ontario.

CNA Publications

Reading the publications of your Association is the surest way to stay continuously up-to-date on the best of current thinking and practice in nursing. Information on these publications may be obtained from the Canadian Nurses' Association.

Homemaker Services

F. Lillian Campion, our Nursing Secretary, attended the National Conference on Homemaker Service held in New York October 12-14.

Discussion centred around the total needs of the family, how homemaker service can meet these needs; methods of establishing homemaker services in rural, country and urban settings; operation of homemaker services in social and health agencies; principles of interagency relationships; training and supervision of homemakers and financing of such services through public and private sources.

While in New York, Miss Campion visited with Miss Helen Mussallem who is attending Columbia University, to discuss plans for the implementation of the recommendations of the Pilot Project Report.

The Unusual

What would be unusual elsewhere becomes almost commonplace for public health nurses in Canada's northlands.

Kathleen Dufton, a native of Radville, Sask., who recently completed a tour of duty in the Yukon, had to travel as much as 600 miles to care for some 3,000 people in her charge. When she visited Pelly River, the only town in the district without a doctor, the hotel owner cleared out the beer parlor and turned it over to her for a clinic!

During the spring breakup, when roads were impassable, Miss Dufton had to travel by helicopter to Klondike City to visit native families stricken with influenza. Most of the time she travelled alone, advising the RCMP when she expected to arrive at her destination. If she was late, someone was ready to set out to meet her.

Northern Health Services supplied her with a car equipped with a sleeping bag, axe, tow chains, matches and emergency rations. "The coldest I have ever driven in was 52 below," she said. "I wouldn't start out in such a temperature. It so happens the cold spell set in while I was out so I kept moving."

Communities she covered included the mining towns and camps at Elsa Keno, Mayo Granville and riverside settlements such as Stewart Crossing and Pelly River. Twice a month she held a well-baby clinic in Dawson City, attending as many as 70 youngsters in an afternoon.

In Memoriam

Canadian nurses were shocked and saddened by the sudden death of **Gertrude M. Hall,** director of nursing, Calgary General Hospital on October 14, 1960. It was a tragic ending to what had begun as a happy occasion for the school of nursing. Graduation exercises, that had included a special presentation to Miss Hall, had just been concluded when death occurred. Thus came to an abrupt close a career of sincere, capable service on behalf of the nursing profession.

The years since her graduation from the Winnipeg General Hospital had encompassed an extensive variety of professional experience and activity. As a young public health nurse in Manitoba, she took charge of health services in Portage la Prairie; taught health education in Winnipeg's normal school and assisted the province's department of health by organizing various health services, surveying nursing homes and developing a nursing manual. Her interest in nursing education was particularly keen. Whenever the opportunity presented itself during these early years, she gave generous assistance to the provincial schools of nursing in their efforts to improve their programs.

Prior to Miss Hall's appointment as general secretary, Canadian Nurses' Association in 1944, she had served for four years as executive secretary and school of nursing advisor, Manitoba Association of Registered Nurses. During the following eight years, as she discharged the demanding duties of the national office, she found time to meet and talk with hundreds of hospital administrators and directors of nursing. Gradually, as she listened to them discuss their problems and plans she developed ideas of her own about the conduct of a school of nursing. The appointment as director of nursing, Calgary General Hospital, in 1952 gave her the chance to put her cherished dreams into action. Directors of nursing everywhere will appreciate the long hours of work, the problems, the triumphs, the failures and successes that have made up the past years. Although endowed with a tremendous capacity for work, the strain eventually proved too great.

Gertrude Hall

Many Canadian nurses will mourn her as a cheery, loving friend. The nursing profession in Canada has lost an able, devoted leader.

Florence (Easton) Anderson, a graduate of Royal Victoria Hospital, Montreal in 1908, died May 15, 1960.

* * *

Norma Anne (Babey) Cunliffe, a 1959 graduate of Moose Jaw Union Hospital, died in a highway accident during the summer of 1960. She had been on the staff of Lloydminster Union Hospital, Sask.

* * *

Gladys M. Dunn, an Ontario nurse, died during September, 1960 in Lindsay, Ont.

* * *

Mary Griffin, a 1911 graduate of Royal Victoria Hospital, Montreal died on February 11, 1960.

* * *

Eva Muriel Haliburton who graduated from Victoria General Hospital, Halifax in 1935 died on October 2, 1960. She had been director of the VGH outpatient department for 10 years. At the time of her death she was a staff nurse at the School for the Deaf, Halifax.

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Elizabeth Hall, a member of the first graduating class of the Owen Sound General and Marine Hospital in 1903, died September 5, 1960. She was 91 years old.

* * *

Nora (Sinclair) Kavanagh who graduated from Royal Victoria Hospital, Montreal in 1927, died July 24, 1960.

Berthe Lapointe, a graduate of Hôpital Youville, Noranda, P.Q., in 1957 died as the result of an automobile accident during July, 1960.

* * *

Mary Hughena MacDonald, who graduated from St. Joseph's Hospital, Glace Bay, N.S. died on January 13, 1960. During a part of her professional career, she devoted much time to the sick and needy in areas of New York City.

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Ethyle L. (McLeish) Mack who graduated from Penetanguishene General Hospital in 1916 died earlier this year in Orillia, Ont.

* * *

Hughena (Campbell) Murray, a graduate of Royal Victoria Hospital, Montreal in 1906, died June 1, 1960.

* * *

Loretta (Charland) Simpson who graduated from Montreal General Hospital, in 1927, died July 26, 1960 after a lengthy illness.

* * *

Eva Welch, a 1901 graduate of Royal Victoria Hospital, Montreal died July 29, 1960.

* * *

Lynne Whittaker who graduated from Royal Victoria Hospital, Montreal in 1955, died April 2, 1960.

There are Two Seas

There are two seas in Palestine. One is fresh and fish are in it. Splashes of green adorn its banks. Trees spread their branches over it, and stretch out their roots to sip of its healing water. Along its shores the children play.

The River Jordan makes this sea with sparkling water from the hills. So it laughs in the sunshine. And men build their houses near it, and birds make their nests; and every kind of life is happier because it is there.

The River Jordan flows on south into another sea. There is no splash of fish, no fluttering leaf, no song of birds, no children's laughter. Travelers choose another route unless on urgent business. The air hangs heavy about its waters and neither man nor beast nor fowl will drink. What makes this difference in these neighbor seas? Not the River Jordan. Not the soil in which they lie; nor the country round about.

This is the difference. The Sea of Galilee receives but does not keep the Jordan. For every drop that flows into it, another flows out. The giving and receiving go in equal measure. The other sea is shrewder, hoarding its income jealously. It will not be tempted into any generous impulse. Every drop it gets, it keeps. The Sea of Galilee gives and lives. The other sea gives nothing. It is named the Dead Sea.

There are two kinds of people in the world. There are two seas in Palestine.

— Bruce Barton

* * *

The word December has a Latin origin, from *decem* meaning tenth. The Roman year began in March making December the tenth month.

NURSING PROFILES

The board of directors of the International Council of Nurses has announced the appointment of **Helen Nussbaum** as general secretary designate. Miss Nussbaum will assume the full responsibilities of this position after the 1961 Quadrennial Congress.

(Nelly's)

HELEN NUSSBAUM

The ICN is the oldest and, in all probability, the largest organization of professional women in the world. The duties of general secretary are many and varied. Their successful fulfillment requires comprehensive experience of nursing on a world-wide scale. This Miss Nussbaum offers in abundance. Born in Sicily of Swiss and British parentage, she eventually obtained her professional preparation in Italy, England and Switzerland. The war years, 1941-45, were spent in district nursing in Switzerland. In 1946 she was recruited by UNRRA for a tour of duty in Greece. After the withdrawal of this organization, Miss Nussbaum remained in the country under the auspices of WHO as a tuberculosis supervisor in liaison with the ministry of health, Athens. In addition to her duties in this area, she opened and directed the first school for nursing aides in Greece.

After completing her assignment with WHO, she undertook a special health mission in the Greek prisons as a member of the International Committee of the Red Cross. Later, as a delegate of ICRC, she was called upon to take part in the relief work required in the Ionian Islands following an earthquake. A year at the organization's Geneva headquarters as deputy chief nurse was succeeded by yet another tour of duty in Greece. On this occasion Miss Nussbaum developed a centre to care for homeless and unwanted babies. She also organized the first school for nursery nurses in the country.

In 1958 she returned to Switzerland as executive secretary of the Swiss Nurses' Association. Many visitors had reason to appreciate her careful planning and generous courtesy. Her fluency in several languages was a great asset in carrying out these duties as it will be in her present role.

Canadian nurses join with their colleagues the world over in welcoming Miss Nussbaum to her new position and extending sincere good wishes for her future happiness and success.

Laura Winifred Barr, has joined the provincial office staff, RNAO, as assistant executive secretary. During the past four years she had been on the staff of the Metropolitan General Hospital, Windsor, first as associate director in nursing service and latterly as director of nursing education. She had previously served as instructor in nursing, Grace Hospital, Windsor and as a clinic nurse.

Born in Japan of missionary parents, Miss Barr completed her basic education in Toronto and entered Grace Hospital, Windsor for her nurses' training, graduating in 1948. She holds her certificate in nursing education from the University of Toronto. She has been an active participant in the activities of the Windsor-Essex chapter, RNAO, and of the district organization. Travel, cooking and membership in the Business and Professional Women's Club occupy spare moments.

Mary O'Brien, the new director of nursing, Grace Dart Hospital, Montreal, is a graduate of Royal Berkshire Hospital, Reading, Oxford City Isolation Hospital, England, and Glasgow Western Hospital where she completed qualifications as a state certified midwife. She is admirably qualified for her present duties, having had particularly intensive training in tubercular work in Scotland. She participated actively in the public relations campaign that preceded the City of Glasgow's mass radiography drive. This project served as a pilot study for similar campaigns in other areas. Miss O'Brien has also had training in various specific areas of tuberculosis treatment such as the use of longterm chemotherapy, domiciliary care, cortisone and collapse therapy.

(Geraldine Carpenter)

MARY O'BRIEN

Since coming to Canada in 1957, Miss O'Brien has undertaken university study towards her arts degree. She enjoys golf, tennis and travelling, her ambition in respect to the latter interest is to see as much of this continent as possible.

Fernande Riverin was recently named assistant director of nursing, Grace Dart Hospital, Montreal. Following graduation in 1939 from Hôpital St-Jean-de-Dieu, she took postgraduate study in psychiatry at the same institution. Her aptitude in this field led to further study at the Centre international de l'Enfance, Paris, and Catholic University, Washington.

Her experience has been varied, ranging from institutional nursing to occupational therapy and, latterly, to supervision of affiliating students at St. Jean de Dieu.

Active in nursing organizations, Miss Riverin is president of her hospital's alumnae association, corresponding secretary and councillor of the Montreal division, Catholic Nurses' Association. Reading, travel and writing are favorite leisure time hobbies.

Mary Elizabeth Macfarland, director of nurses at Toronto General Hospital since 1942 has announced her retirement. A graduate of TGH with her certificate in teaching and supervision from the University of Toronto, Miss Macfarland has given long and devoted service to her alma mater. After several years as head nurse of the gynecological ward, she became supervisor and instructor of the medical division following her university experience before succeeding to the position from which she has retired.

Her contribution to the life of various professional organizations has been equally outstanding. She is a life member and past president of her alumnae association; a member of the nursing committee, Ontario division of the Canadian Red Cross Society; a member of the advisory committee for the school of nursing, University of Western Ontario.

MARY MACFARLAND

Under her capable guidance the nursing department of TGH has made noteworthy progress. Her personal loyalty, integrity and devotion to her hospital influenced the lives, both personal and professional, of the many nurses with whom she came into contact.

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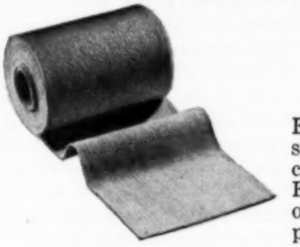

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The Selection of Learning Experiences

FLORENCE E. ELLIOTT

To assist schools of nursing in upgrading their educational programs, the CNA has been working towards the development of a curriculum guide. This is the third of a series of four articles on this topic.

THE PRESENT GENERALLY accepted definition for a curriculum ackowledges that it goes beyond subject matter content to include all of the learning experiences that are planned and controlled by a school.

This modern concept of curriculum has particular significance for nursing education. A far too common feature in schools of nursing is the educational program that has two rather separate parts: 1. Those experiences that are carefully planned and controlled by the faculty, and 2. another whole set that can be called "learning experiences" only by virtue of the fact that every experience that we have contributes to our learning. The faculty plans only very sketchily for the latter and control lies with another group. The term *learning experience* is used to refer to any event that is planned to assist the student to achieve the objectives of the curriculum. Such experience, in accordance with this definition goes beyond the care of patients to include formal classroom presentations, patient-centered conferences and student-instructor conferences.

Perhaps it would be well to consider the process of curriculum development as *curriculum building*. This provides a mental picture of the curriculum as a pyramid. Its apex is the purpose of the school. Supporting the apex are the objectives of the curriculum. These in turn are supported by the individual course objectives, all of which contribute their share in the achievement of the curriculum objectives. At the base of the pyramid are the learning experiences designed to achieve the course objectives. The mortar that holds the bricks of this structure together is the school's philosophy of nursing and nursing education.

Criteria for Selection

How do we select learning experiences? Each one should be chosen for its worth in achieving specific educational objectives. Faculty members must be prepared to answer the questions, "What is the educational outcome expected?" and, "For what purpose is this experience planned?" in relation to each experience that is included as a part of the program. We should select experiences in terms of what we know about the learning process. Here we utilize the data accumulated by research in the field of educational psychology.

1. *Individuals learn most effectively when they are interested.* This reminds us that the student will benefit most from an experience which she recognizes as contributing something of value to her own goals. For her as well as for the instructor there is a good reason for the experience. As instructors, we cannot impose *our* goals on the student. We are most successful when we capitalize on the student's interests and help her to develop worthwhile objectives for herself.

2. *Learning depends on what one wants to learn.* An individual learns best when he is free to create his own responses to a situation. Are we able to create a student-teacher relationship that is based on mutual respect and permits the student to find the answers in her own way? Does the student feel free to respond spontaneously? Does the student feel comfortable enough with the instructor to react naturally or does she perform in the way that she knows is expected? Does our system create tensions or pressures that seriously re-

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Miss Elliott is the director of the study on cost of nursing education with the National League for Nursing. She presented this paper at the Curriculum Workshop, Canadian Nurses' Association in 1959.

strict the amount of learning that takes place?

3. *Learning depends on not knowing the answers and finding them.* Students must be encouraged to raise their own questions. They should be guided to *find* answers in preference to being *given* answers. A serious limitation of the lecture method is that the subsequent regurgitation of facts by the student may very well mean that she may not recognize what she does not know. Learning experiences should be planned so that the student is helped to see the application of scientific principles to nursing situations; to analyze and examine nursing situations in the light of her theoretical knowledge; to select the principles that she believes apply to the specific situation and to try them out.

4. *Learning is largely a behavioral experience.* To learn is to change. The teacher cannot *give* learning to students. Is this not particularly significant in nursing education where a thorough knowledge of facts alone does not mean that an individual will be effective in nursing practice?

Self-activity is necessary for learning to take place. A student should have learning experiences that provide an opportunity to practise the kind of behavior required by the stated objectives. Repetitive activity is not sufficient. The activity must be related to the goal and the student must see the relationship. Learning is developmental. Learning experiences should be organized in a continuum so that each new experience reinforces the previous one. There should be an orderly arrangement with progression from the simple to the complex and with a reasonable distribution and balance throughout the program.

Bronchogenic Carcinoma

MONA EISENSTAT

Because lung cancer incidence is increasing and there are no strongly suggestive symptoms which might bring the patient to the doctor, nurses will care for an increasing number of patients who are in the advanced, inoperable stage of this disease.

Incidence

BRONCHOGENIC CARCINOMA accounts for 5 to 10 per cent of all cancer deaths.[3] It is the most common cancer site among men over the age of 45 and six times more frequent in men than in women.

Location

Tumors develop in the mucosa of a broncus, usually in the upper lobes. Many, if not all of them, pass through an apparently benign stage. These benign adenoma of the bronchus must be considered premalignant. As they grow, most of them cause obstruction, sometimes with secondary bronchiectasis and lung abscess. (Bronchiectasis is a chronic disease of the bronchi characterized by dilatation of the tubes associated with changes in the walls, favoring chronic suppuration.) The tumors infiltrate the surrounding lung tissue, causing irregular areas of consolidation. Sometimes they cause pleural effusions, which are frequently bloody and contain tumor cells that may be identified in the centrifuged sediment from the fluid.[3]

Symptoms

The growth of new cells produces bronchial narrowing and eventually a cough with dyspnea develops. The symptoms depend upon the size and location of the new growth. If it is small and located in the main bronchus, there may be a cough. If it is in a

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Miss Eisenstat who is a student at the Jewish General Hospital in Montreal, was awarded honorable mention for this study in the recent Macmillan Award competition.

small bronchus in the periphery of the lung, it may grow to a considerable size before producing symptoms. Hemoptysis (spitting up of blood) may be the first symptom and can lead to an investigation which reveals the cancerous lesion.

Causes

The cause of cancer of the lung is unknown but it is believed that chronic irritation contributes to its development. Occupations in which the workers are exposed to radioactive substances or to certain chemicals are felt to be of significance. A history of heavy smoking is common and it is thought that this may be a factor contributing to the disease.[4]

Types

There are three pathological types of bronchogenic carcinoma:

1. Epidermoid or squamous cell carcinoma.
2. Adenocarcinoma.
3. Oat cell carcinoma.

The first two originate in the bronchi or bronchioles. The latter is thought to originate in the alveoli. It is the epidermoid or squamous cell type of carcinoma that is showing an increased incidence.

Course of the Disease

Metastases occur to the mediastinal and cervical lymph nodes, the walls of the esophagus, the pericardium and the opposite lung. Advanced cancer of the lung causes marked dyspnea with wheezing, weakness, loss of weight and appetite, cough and pain.

Bronchogenic carcinoma gives rise to lymphatic metastases early in the course of the disease. From the involved bronchial and mediastinal lymph nodes further extension soon occurs, both upward to the supraclavicular nodes and downward to nodes around the abdominal aorta — thence to the liver and adrenal glands. Dissemination by the blood stream is frequent, so that brain metastases are prone to occur.[1]

Suffering in the terminal stages is often extreme. At times, the course of illness appears very slow and the patient's life is made miserable for months by severe pain, dyspnea, harassing cough and foul sputum. Uncontrollable hiccoughs, alarming hemorrhages, headache and loss of vision due to cerebral metastases are typical sequelae that combine to make the patient's existance intolerable.

Treatment

As both the public and physicians become more cancer conscious, an increasing number of cases are diagnosed early and the patients saved by lobectomy or pneumonectomy.

X-ray treatment may be helpful but is not curative. The objective of radiation therapy is to deliver a lethal dose to malignant cells and at the same time limit injury to normal tissue. Whenever radiation is used extensively, radiation sickness may occur. This condition, according to present theory, is brought about by the liberation of the products of protein decomposition due to the death of a large number of cells at one time. The major symptoms of radiation sickness are: anorexia, nausea, vomiting and mental depression.

If the tumor is very extensive, the mediastinal glands involved, a gangrenous pleural effusion has formed, or if metastases have become established the disease is generally inoperable. Treatment is then syptomatic, aiming at keeping the patient as comfortable and free from pain as possible.[3]

The Patient — Social History

Born in Poland in 1907, Mr. Mendel migrated to Montreal at the age of 18. He cannot write or read any language but can speak five languages fairly well.

He worked at odd jobs for the first few years and then started a "junk" business with his father. He met his wife when he was in his early twenties and they had a most happy marriage. He has two sons who are now in their twenties. Tragedy struck two years ago when Mrs. Mendel passed away after a long illness. Her death at a convalescent home occurred while Mr. Mendel was hospitalized and he discharged himself to attend the funeral. He had been taking care of her prior to his admission to hospital. His business had been neglected.

The family finances were very meagre. His younger son had had a "nervous breakdown" due to his mother's death and his older son, a taxi driver, had only a small income. The younger son, who is very devoted to his ill father, cannot

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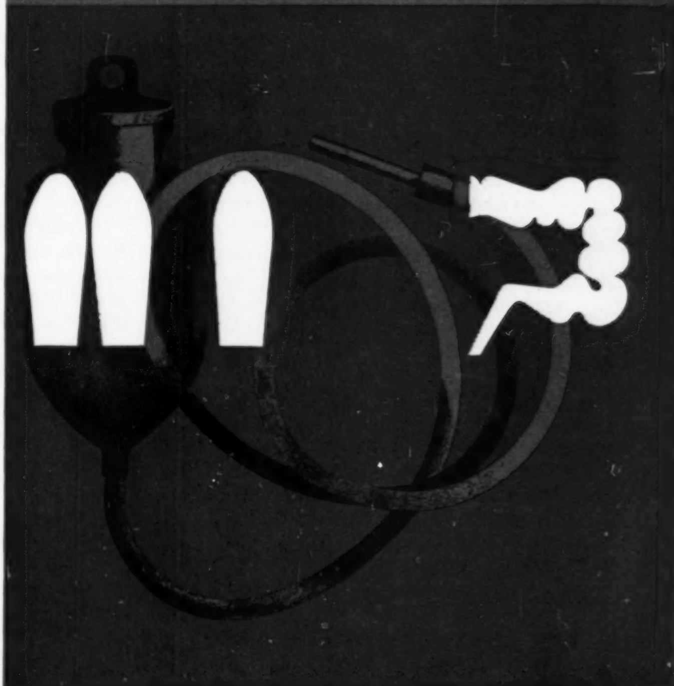

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keep a job for any length of time. The older son has a wife and family to support in addition to helping his father, younger brother and 80-year-old grandfather.

Prior to Mr. Mendel's illness, he was a very strong, independent fellow weighing over 200 pounds. Although he never had much money, he managed to maintain a comfortable home. There was a very close relationship between the members of this family. Now, two years later, Mr. Mendel weighs less than 100 pounds and is a very nervous, irritable and demanding man who cannot accept his illness. He has not been told that he has cancer; he thinks that he has had a benign tumor removed and that there is now an "inflammation" in his chest. His immediate family know the diagnosis and the probable outcome of the disease.

Mr. Mendel is Hebrew, but is not religious and does not care to discuss it. It is interesting to note that he has smoked three packages of cigarettes a day for the past 25 years.

Previous Admissions

Mr. Mendel was never seriously ill prior to his first admission to hospital in the spring of 1957. He had had a cold which lingered for some time and consulted a doctor who admitted him for further investigation. A diagnosis of bronchogenic carcinoma of the left lung was made and a left pneumonectomy was performed.

Pneumonectomy is the removal of an entire lung. The nature of the disease and the extent of the lung involvement may make surgery difficult. A posteriolateral thoracotomy incision with resection of the third or fourth rib is made. The pulmonary artery and vein are ligated and divided; the main branches are resected, closed and covered with adjacent tissue. The phrenic nerve is crushed to allow the diaphragm to rise on the affected side and thus obliterate the cavity which remains following removal of the lung.

After an antibiotic solution is injected into the cavity, the incision is closed without drainage tubes. The cavity is smaller than normal because of the elevation of the diaphragm on the operative side and the slight shifting of the mediastinum. Normal negative pressure found in the chest draws fluid into the cavity from the surrounding tissues. This fluid becomes incorporated with red and white blood cells and eventually a cheese-like material forms and fills the space preventing the other lung and the heart from shifting toward the affected side.[5]

The patient felt fairly well after the operation. He was discharged in two months and returned frequently to the clinic. The wound did not heal properly and two months after discharge he was readmitted because empyema had developed (empyema is pus in the pleural cavity). A rib resection and drainage was done and the patient was discharged with a Pezzer catheter in his left hemithorax. Four months later it was removed, but soon had to be reinserted.

Mr. Mendel was readmitted for the fifth time for residual empyema and emphysema (the alveoli lose their elasticity and become distended). The social service department arranged for him to convalesce at a sanitorium in the country. However, in two weeks he was returned to the hospital by ambulance.

Present Illness

While at the convalescent hospital, Mr. Mendel had been coughing and spitting small amounts of blood. His hemoglobin had fallen to 60 per cent. Two blood transfusions were given raising his hemoglobin to over 75 per cent.

An examination of his chest revealed the presence of a large pleural effusion on the left side. The left diaphragm appeared quite elevated with many distended loops of bowel beneath it.

A bronchoscopy was done. A bleeding site was noted at the stump of the left bronchus. His left vocal cord was found to be completely paralyzed, his right cord normal. Mr. Mendel has a hoarse voice and whispers.

An x-ray of the lumbo-sacral spine revealed a scoliosis to the left, but no definite destructive lesion.

Mr. Mendel complained constantly of pain in his legs, especially the left — sometimes so severe that he would sob for hours. He received various medications for the pain, given every four hours whenever necessary, but he would cry for an injection or pill after two or three hours, especially during his last weeks in hospital.

Nursing Care

Mr. Mendel refused to get out of bed even though the doctors urged that he should. He remained on his right side day and night so that even making his bed presented a problem. He was very jealous and demanding. If the patient in the next bed asked for something while Mr. Mendel's back was being rubbed he would say "She has to finish with me first. Everyone always disturbs me when I am being cared for. Wait your turn." He was rude and unreasonable at times, but his illness and suffering explained his actions.

At times, the patient would become quite depressed and ponder doubtfully about his recovery. He did not try to put on a good front for his family. He cried when they came and they would share his misery with him. His sister and his sons felt very inadequate because there was nothing they could do to lessen his suffering.

In addition to drugs Mr. Mendel received 20 Cobalt 60 treatments. The nurse can do much to aid in overcoming the patient's fear of the treatments by assuring him that although he may have some discomfort from them it rarely lasts more than a few hours and the doctors will order medicine to stop most of the symptoms. Mr. Mendel was carefully informed about the therapy. He was told that he would be placed in a room by himself but that there would be a radiotherapist outside the room all the time with whom he could communicate. It was explained that the equipment was similar to what he had seen during routine x-rays. He was informed that one day he would receive the treatment on his chest and the next day on his back. He did not fear the actual treatments but dreaded the after effects. When he learned that the medications would prevent him from vomiting he was more at ease.

Routine physical care was given in addition to special back care. Normal tissue reacts to the radiation treatment and great care must be taken of the skin. No soap or alcohol was used on the treated area, nor was it washed vigorously or massaged. No adhesive tape was used on his back or chest during the period of therapy as it interferes with the rays and the skin is hypersensitive to it.

During the long course of radiation the patient may need supplementary drugs to aid in maintaining adequate nutrition. Mr. Mendel received Vitamin B_{12} 1000 mg. intramuscularly twice a day. He was on a regular diet but his appetite was poor except at breakfast time when he would eat everything.

Discharge Plans

The social service department arranged for Mr. Mendel to be discharged to a convalescent home. The city will pay his expenses. For the first two weeks he really enjoyed being there. Now, a month later, he is complaining that he needs to be in the hospital. His hopes of recovery are gone and he no longer thinks about spending the summer in the mountains with his father.

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At sundown on December 25th, Jews throughout the world will start celebrating the first day of Hannukah, the Feast of Dedication. This festival was instituted by Judas Maccabaeus in 165 B.C. to celebrate the purification of the Temple of Jerusalem, which had been desecrated by Antiochus Epiphanes. Also called the Festival of Lights, the feast lasts eight days. One light is kindled on the first night and an extra one added on each successive night. Hannukah represents a time of good fellowship, family gathering, the exchange of presents and merrymaking.

— *The Bulletin,* Vol. 38, No. 12

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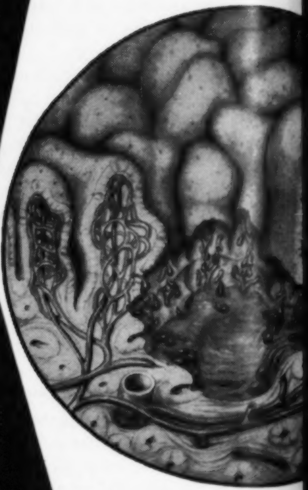

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Two Degrees above the Equator

Sister Mary Frances Xavier, o.l.m., S.C.M.

With world-wide attention focused on Africa and on Nigeria, as the final steps were completed to proclaim independence on October 1, 1960, readers may be interested in knowing something about nursing, two degrees above the equator.

Canadian nurses, like good citizens, are at home anywhere in the world — whether it be working in a Red Cross outpost in the frozen wastes of the far north; supervising a hospital in one of Europe's refugee camps; or driving along a bush path, almost hidden by mango trees and thick foliage, en route to a native village for dispensary work in tropical Africa. Wherever she is, the Canadian nurse practises a high standard of nursing care.

The northern region of Nigeria, has a population of approximately 33,000,000, mainly composed of Moslems. The vast majority of the people are uneducated. Native doctors practise their arts often with disastrous results. Ju Ju, a belief in native witchcraft, is followed by the majority, and "white man's medicine" is regarded with suspicion. It is not uncommon to see a small child wearing around his neck a multitude of trinkets, bells, and crocodile teeth to "keep the evil spirits away and make the baby strong."

There are four Canadian nurses from a religious order working in Okene, in Kabba Province. The town has 140,000 people and is situated near the boundary of the northern region. A new 120-bed general hospital is under construction. At the present time there is accommodation for 75 patients. Eventually, the hospital will have a school to train the Nigerian girls. An Italian doctor is in charge of the hospital. He and his wife, who is a pharmacist, work untiringly for the benefit of the people. Although supplies and medical equipment are limited and working conditions difficult, the doctor has endeared himself to his patients. It is particularly in the field of obstetrics and gynecology that medical aid is so invaluable.

A few months ago a young woman, Amanatu, was brought to us almost unconscious. She had been literally "dropped off on us" by a passing truck. Her condition was fair, pulse 100, a full-term pregnancy with the caput present on the perineum. She was a primipara and had been in labor for four days with many native doctors in attendance. It was apparent that operative delivery would be necessary.

Amanatu was transferred to the delivery room and routine admission treatment given. Her blood pressure was 90/50; temperature 100° F.; pulse 100; respirations 20. Abdominal palpation revealed a fundus at the level of a 40-week pregnancy. The fetus was in the L.O.A. position, the head was not engaged. The fetal heart was not heard. The mother was prepared for a forceps delivery. Morphia gr. 1/6 was given subcutaneously. Upon vaginal examination it was discovered that Amanatu had a contracted pelvis.

If undiagnosed, a contracted pelvis will give rise to prolonged, difficult and obstructed labor. This may result in injury or death of mother and child. A pelvis is contracted when one or more diameters are over one centimetre less than the minimum normal range, thereby making the delivery of an average-sized baby by the natural route difficult or impossible. Female pelves have been classified by Caldwell and Moloy into four basic types each one is designated according to the shape of the brim. The differences in shape are thought to be due to racial and familial inherited characteristics or to endocrine influence, but not to disease.

Amanatu had a justo-minor or gen-

Sister Mary Frances Xavier, a graduate of Hotel Dieu Hospital, Cornwall, Ont., is a member of a Canadian order of religious sisters devoted to medical and teaching work in foreign lands. At present she is stationed in Nigeria.

erally contracted pelvis with cephalopelvic disproportion.

A symphysiotomy was done. This is not a popular procedure in Canada where Caesarean section is the method of choice. It is carried out in Europe in selected cases and excellent results are obtained. The operation consists of an incision, under local anesthetic, through the abdominal wall. Then the symphysis pubis is divided. This gives the pelvis approximately one-half an inch increase in diameter. A bilateral episiotomy was made, but as there was still a slight contraction it was necessary to do a craniotomy on the baby. She was delivered of a dead child.

Due to shock and blood loss, Amanatu's blood pressure was 70/50; pulse 160; respirations shallow. Coramine 2 cc. was given intramuscularly. An intravenous solution of 1000 cc. 5 per cent glucose and saline was begun, while the episiotomy and symphysiotomy were being sutured. Later, the patient was transferred to the maternity ward and the foot of her bed was placed on blocks in shock position. A second bottle of 1000 cc. 5 per cent glucose and saline was given and another injection of Coramine 2 cc. A Foley catheter was inserted. The doctor left orders for antibiotic therapy and administration of Stilbestrol. Amanatu's condition improved quickly and she spent a comfortable night.

Nursing care consisted of a daily bed bath and routine perineal care. Acroflavin compresses were ordered to be applied to the perineum, which was very edematous. Amanatu was instructed to do deep breathing exercises to prevent hypostatic pneumonia. Particular care was taken to posture the patient with her legs together in order that the bones of the symphysis pubis would unite in correct alignment.

On her third day postpartum, the Foley catheter was removed and Amanatu voided normally. A tight binder was applied to her breasts. On the seventh day she sat on the side of the bed. Two days later she was able to be up and walking. The symphysiotomy incision was completely healed. No deformity in gait was noticeable.

Amanatu was instructed about the importance of antenatal care, and of regular attendance at the hospital clinic during any future pregnancy so that abnormalities might be detected. She was advised, also, that Caesarean section would be a necessity due to her contracted pelvis. Her diet was discussed and she was taught how to include adequate protein, especially in the form of liver and eggs. Most of the diets of the people in this area are deficient in protein, which causes a form of anemia. They also lack vitamin B which leads, in severe cases, to beriberi and subsequent heart damage.

Amanatu was discharged on her 16th day in excellent health. She was anxious to return to her native village and to her own compound. Many maternal deaths could be prevented in Africa by good antenatal care. We hope that Amanatu will prove an effective public relations agent for the hospital and direct many women to the clinic.

Parents beware! Holiday decorations are potentially toxic.

The bright colors, movement and light of bubbling Xmas tree lights make them particularly alluring to small children. Small amounts of the fluid, when ingested, will cause CNS depression, but large amounts may cause late liver and kidney damage.

Inhalation of snow sprays may result in foreign-body irritation in the lungs. Watch for signs of aspiration pneumonia.

The metallic salts that cause multi-colored flames when thrown in the fireplace, will cause intense gastrointestinal irritation if ingested. If the trade name of the salt is known a specific antidote may be prescribed; otherwise emesis should be induced by administration of a demulcent.

The berries of holly and mistletoe are both toxic. Treatment following ingestion consists of inducing vomiting.

Prevention can avert tragedy.

— *Hospitals,* Vol. 33, No. 24.

* * *

To iron puffed sleeves and to get at hard places, fold a heavy wash cloth over the fingers and insert them under the surface.

— *Alumnae News,* Hotel Dieu of St. Joseph, Windsor.

CEREBRAL PALSY

MARILYN SPICER

It is easier for parents to do for a child with cerebral palsy than to help him to do for himself. They need as much patience and understanding from the nurse as they in turn will need in the care of their child.

Cerebral palsy occurs in three different forms:

1. *Spastic:* The child has suffered damage to the motor area of his brain, the part that translates desire into action. His muscles are tense and contracted, pulling and twisting his face, arms, legs and body.
2. *Athetoid:* The damage is in the brain stem. It accounts for the second largest group of cerebral palsy victims. The muscles affected are in continual, purposeless motion and cannot be directed into organized action. Athetoid children have been called "prisoners within a framework of constant unwanted motion."
3. *Ataxic:* This group represents a small percentage of cerebral palsy children. This child walks with a staggering gait which gives him a very clumsy appearance.

A child with cerebral palsy may have a combination of types but usually one type predominates.

Cerebral palsy is not a disease. It is an abnormality caused by injury to the unborn child either during pregnancy or at delivery. It can be caused by a disease such as meningitis following birth. Cerebral palsy is not hereditary. It is no reflection on the physical or mental health of the parents.

A cerebral palsy child is an individual, with the same needs and fears as a normal child. He does not notice that he is different from others until he becomes older. Then he may become very frustrated because he cannot do tasks with the same speed and confidence that others can. He cannot play on an equal basis with other children. Because of his clumsy movements and persistent drooling, many people mistake him for a mentally retarded child. Actually, most of these children are perfectly normal in their thinking. However, it is true that some of them have brain damage and are mentally retarded.

Although the majority of these children cannot converse intelligently, they understand others well. They learn at their own pace — usually very slowly — and must be encouraged to do so. However, they must not be babied or overprotected. They should never be laughed at or ridiculed since they are very sensitive. Cerebral palsy children can be helped. Parents should not give up hope or faith. If they accept the child with love and understanding, he will be more easily accepted in the community. Most people have some handicap and cerebral palsy is only one of the many. Sometime in the near future, a successful treatment may be found.

Diane's Story

Diane, a pretty little blond-haired girl, was affected with cerebral palsy. Her father worked as a mechanic in a local factory and provided a steady income for his family. Both he and his wife are Canadian-born. The family live in a four-roomed frame house. Their home is neat, clean and tidy with a pleasant atmosphere. The family live moderately well and seem quite happy together.

Diane was born five years ago in a local hospital after a normal, full term pregnancy. However, the mother's labor was long and the baby was delivered instrumentally in a face presentation. She appeared to be normal and weighed seven pounds and fourteen ounces. At the age of five months, she cut her first tooth. At six months she started her immunization program. At eight months she was unable to sit unsupported, and her head fell forward.

The public health nurse visited the

Miss Spicer wrote this study during her senior student year in the school of nursing, Civic Hospital, Peterborough, Ont.

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NIAGARA FALLS, CANADA

1. A.M.A. Journal of Diseases of Children 95: 109-119, 1958
2. Publication 589, National Academy of Sciences, National Research Council

home shortly after Diane's birth to see if she could help the mother in any way. She found her interested and cooperative. The following spring the nurse again visited the family. She noticed that Diane did not have full use of her right arm and leg; that she did not sit alone and that she was unable to hold her head upright. Her right thumb was folded into the palm of her right hand. She had some weakness of her eyes. However, the pediatrician felt that nothing could be done at that time.

Diane was admitted to a children's hospital on three occasions within three months. Investigation revealed that she was reasonably alert mentally although she had left-sided brain damage. It was observed that her right calf muscles were taut and that she would bear weight on her right toes only, when walking. She had spasms of falling forward (as many as 12 falls in succession). Sudden convulsive twitchings of her body were noticed occasionally. She was given a compound of dilantin and her convulsive disorder became less pronounced. The need to strengthen her back and neck muscles was stressed. A return visit to hospital was for this purpose.

Diane's parents were visited again by the public health nurse who suggested the groups available in the community where they could receive necessary assistance. They were urged not to become slaves to their daughter but to let her lead as normal a life as circumstances allowed. Diane's progress was fairly satisfactory for the next two years. Petit mal seizures were no longer troublesome. She was holding her head upright and seemed to notice what was going on about her. Her left eye tended to turn inwards when she was tired. Growth of her right side appeared normal. Her mother seemed very interested in the suggestions made by the nurse to help the child. She was referred to the Crippled Children's Society for help.

The nurse discovered that Diane was being fed by her mother. The importance of providing opportunities for learning was again stressed. About six months later Diane was still being fed and independent feeding methods were discussed. The nurse was unable to convince the mother that she could do much more for her daughter by giving her a chance to do things for herself.

Not much improvement has been made in recent months. However, Diane walks for short distances and is bearing weight on her good left side. She walks on the toes of her right foot. She is still being fed by her mother. She has a high shrill cry and has been taking 10-15 petit mal seizures daily. She shows great affection at intervals but does not appear to comprehend words. Music interests her and she listens to it contentedly.

The nurse has constantly and repeatedly suggested ways to help Diane and her parents. This advice has apparently been given in vain. The parents are interested in their child's welfare but will not accept her abnormality as part of their daughter's life. They also lack the initiative to help Diane to help herself. In years to come, Diane may become a great burden to her parents as a result.

Mistletoe is a parasitic, evergreen plant which grows on many trees, especially on the oak and the cypress. In olden times the Druids regarded it with great veneration. The priests gathered the plant with a golden knife on the sixth day after the first new moon of each year. They divided it with ceremony and distributed it to the people who wore it as a charm to ward off evil.

— *New Educator Encyclopedia,* 6:2371

* * *

Under the influence of St. Francis of Assisi in the 13th century, Christmas carols evolved into their present form.

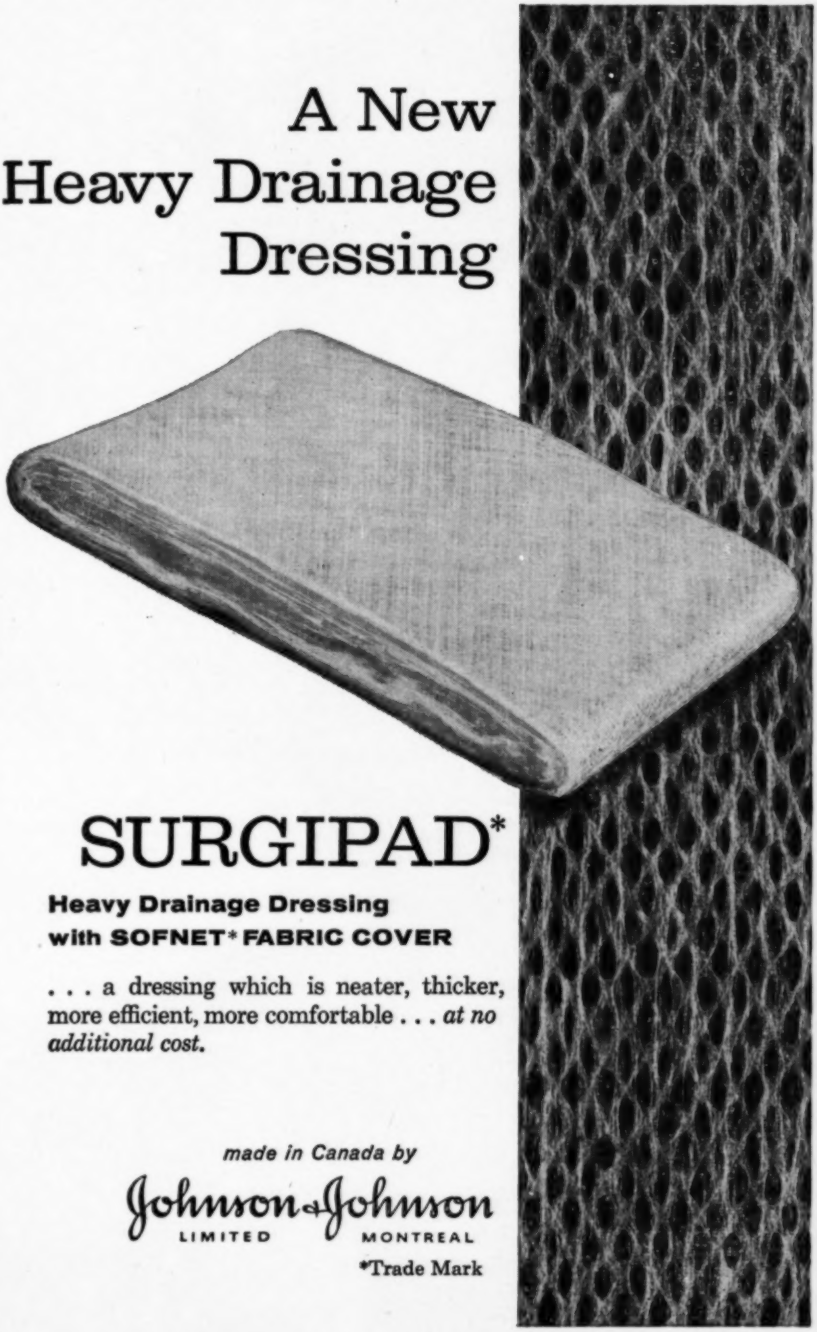
The poinsettia was discovered in Mexico in 1828 by Dr. Joel Poinsett, the first U.S. minister to that country. There, it was called Flor de la Noche Buena (Flower of the Holy Night) with its legendary origin being from the drops of blood that fell from the broken hearts of maidens disappointed in love.

— *American Practitioner* Vol. 10, No. 12

* * *

At Christmas I no more desire a rose
Than wish a snow in May's new-fangled mirth;
But like of each thing that in season grows.

— *Love's Labour Lost,* SHAKESPEARE



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FRACTURE OF THE MANDIBLE

Carole (Eldridge) Stevens

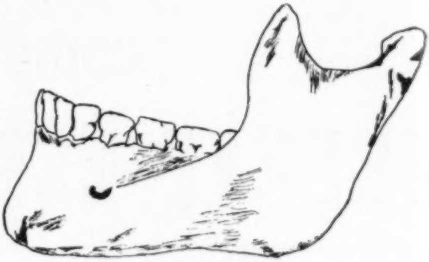
Although recovery from an injury such as this can be relatively uncomplicated, there are various emotional and psychological aspects to be considered as well as possible physical problems. It should not be dismissed as a minor condition requiring a minimum of nursing attention.

Facial Injuries in General

In the past few years the number and speed of cars on our highways has been steadily increasing and there has been a proportional rise in the incidence and severity of facial injuries as a result of accidents. In the treatment of these cases doctors and nurses must recognize the importance of good cosmetic results. These patients have a very real fear that the damage will be irreparable. Apart from the need for good surgical and medical care, so that scarring and deformity is minimized, patients with facial injuries require constant reassurance and psychological support. They need understanding help in adjusting, and accepting the situation.

The Mandible

This is a single symmetrical bone forming the inferior anterior portion of the facial skull. It is the only bone in the skull that is movable. It consists of a convex body or *corpus* which forms the chin and supports the teeth, and a broad plate on each side called a *ramus* which projects backward and upward forming two processes. The posterior one articulates with the mandibular fossa of the temporal bone. This joint allows many varied movements of the jaw: elevation, depression, extension, retraction, side to side, and a combination of all these to give the gliding motion necessary for mastication. The jaw consists of a U-shaped cortical or outside layer of hard bone and an inner layer of softer cancellated bone. The blood supply arrives via the mandibular artery, and motor and sensory nerve impulses are supplied by the trigeminal or fifth cranial nerve.



The Mandible

Due to its exposed position the mandible is fractured more often than any other facial bone. The cause of fracture is usually a hard blow.

Symptoms of a Mandibular Fracture:

1. pain and tenderness — aggravated by movement
2. deformity — due to the direction of force, gravity, or muscle pull
3. swelling
4. abnormal motility — due to break in bone continuity, loose teeth
5. discoloration — due to effused blood
6. interference with chewing — teeth are out of line
7. crepitus — grating of bone when broken edges meet
8. possible gum laceration at the fracture site.

Diagnosis is made by signs, symptoms and x-ray confirmation which gives the direction, type, and severity of the fracture. Treatment is aimed at restoring normal position of the segments and fixation of them until union takes place. The principal guide for positioning is the relationship of the upper teeth to the lower, and of both sets to the oral cavity. The surgeon must have an accurate knowledge of this relationship so that proper occlu-

---

Mrs. Stevens who very recently graduated from the Royal Columbian Hospital, New Westminster received Honorable Mention for this study in the Macmillan Award competition.

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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sion and mastication may take place after the fracture has healed. The length of time until union occurs depends on the number and character of fractures and the reparative powers of the individual. The average is three to five weeks if there is no suppuration or bone loss. Good oral hygiene during this period is a must if infection is to be avoided and primary healing to take place.

Introducing the Patient

Mrs. Peel was a short, slight, rather nervous woman who had completed grade eight education before her marriage. Twelve years ago she moved to the West coast with her family — a daughter, now 21 years old, who was married three years ago, and a 13-year-old son who suffered from nephrosis and had lost three years of schooling as a result.

The patient had never been in very good health. She had had three attacks of rheumatic fever at 10, 24 and 25 years of age — one of which was complicated by scarlet fever. Two years ago she underwent abdominal surgery. She and her son are under the care of the city Social Assistance department since the mother has not been able to work recently. Previously, she had spent three years as a maid in a hotel and as a worker in a laundry. As leisure time activities she enjoyed sewing, reading and watching television.

Following a party one evening the car in which Mrs. Peel was riding skidded off the road and struck a telephone pole. She was admitted to the emergency department via ambulance stretcher for treatment. Questioning revealed that the patient remembered nothing about the accident, and that apparently she had been unconscious for some time.

Examination revealed:

1. Multiple facial abrasions
2. Lacerations of left lower and upper lip, left knee, right hand
3. Sanguinous oozing from nostrils
4. Contusions of ankles, left forearm, left eye, left clavicle
5. Pain on pressure over left mandible
6. Upper rim of upper denture broken
7. Pupils equal and reacting
8. B.P. 100/70, pulse 108.

X-rays of the extremities revealed no fractures or dislocations, but the radiologist reported that:

> The P.A. and lateral stereoscopic and oblique view of the mandible show a fracture through the base on the left side with minimal outward displacement of the proximal fragment and separation between the fragments amounting to a few millimeters. There is fragmentation at the fracture site with a 1 x 0.3 cm. fragment of cortical bone separated at the fracture line and lying obliquely between the distal and proximal fragments.

Demerol 75 mg. was given immediately to relieve the pain, and the facial lacerations were carefully cleansed and sutured with fine black silk. Close attention was paid to cosmetic effect. The doctor ordered 1500 units of ATS as a preventive measure against tetanus and a skin test was done. Because the results were positive the remainder of the dose was not given.

Tetanus Antitoxin

Use — Prophylactic dose of 1500 units where wounds are contaminated with soil, street dust. Treatment of tetanus — 50,000 to 100,000 units for first few days I.M. and I.V.

Sensitivity test — Carried out each time antitoxin is administered. Inject intradermally 0.1 cc. diluted 1:10 with sterile normal saline. If patient is hypersensitive to horse protein a wheal with hyperemic areola forms in 5-10 min. showing that he will react unfavorably to the antitoxin. This must be reported to the doctor. If the test is negative, give the remainder of the 1500 units I.M.

Treatment of tetanus — Saturate body with antitoxin until symptoms subside. Avoid stimuli.

Precautionary measures — Has patient a history of allergy, asthma or hay fever? Has patient ever had toxoid or antitoxin before?

Desensitization — Small initial dose, then larger doses at 20 min. intervals until desired amount has been given.

Serum reactions — Anaphylactic: give 0.5 cc. epinephrine hypodermically. Thermal: 20 min. — 1 hour after injection, chill, dyspnea, fever. Serum sickness: fever, rash, edema, joint pain — two weeks after injection.

The Preoperative Period

Upon her arrival in the ward Mrs. Peel was settled comfortably in bed. Her blood pressure, pulse, and tem-

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perature were taken, and she was observed for signs and symptoms arising from her injury. Hospital routine was explained and she was oriented to her room and equipment. A mouth care tray with a solution of one-half hydrogen peroxide and one-half normal saline was set up at the bedside and the importance of its frequent use was explained. Because it was observed that this patient was slightly disoriented at times, bed rails were applied. Close observation was made for signs of respiratory distress or shock.

Mrs. Peel was hospitalized for six days before her surgery and during this time emphasis was placed on:

1. *Relief of pain* — Demerol 75 mg. was given during her first night for severe pain and restlessness but it did not need to be repeated since aspirin and phenacetin compounds were found to be effective. Mrs. Peel's denture was repaired and the nursing staff was requested to encourage her to wear it even though it was painful, due to small lacerations on her upper gums. Nupercainal ointment applied to the denture before insertion relieved some of the discomfort, but the patient still complained of pain travelling to her left ear whenever the denture was in place.

A tensor bandage with chin padding was applied to help support the mandible. It was of some help in relieving the pain.

2. *Strict oral hygiene* — Mrs. Peel was encouraged to use mouth wash frequently. Mouth care was given at intervals throughout the day by the nursing staff. Her denture was brushed following meals and soaked in a very weak solution of mouth wash during the night. When it was explained that this routine was necessary to prevent infection of the mouth glands, fracture area, and gum lacerations, and to speed up the healing process, the patient was very cooperative in carrying out the routine as she had been instructed.

The sutured lacerations around her mouth were cleansed frequently with peroxide. They appeared to be healing well. During her second day in hospital Chloromycetin 500 mg. stat and 250 mg. q.i.d. were ordered as an added precaution against infection.

3. *Diet* — Because of the nature of her injury, Mrs. Peel was placed on a high caloric fluid diet arranged especially for her by the dietitians. She tolerated it very well although she found fluids for every meal became very tedious. The value of such a diet in preparation for surgery was explained.

4. *Explanation, reassurance and psychological support* — Consideration for her feelings, tact, understanding, and reassurance played a big role in the nursing care of this patient. In order for her to accept her condition it was necessary for the nurses to demonstrate calm acceptance of it.

As preparation for the postoperative period and the time of discharge, and in an attempt to relieve fear, anxiety and apprehension Mrs. Peel was given explanations of procedures being used and those that she could expect later on. She was told that a urinalysis and blood tests would be carried out to help the doctor gain a picture of her general health; that skin preparation done the night before surgery would help to prevent infection. The anesthetist visited her to check heart and lung action and to choose the anesthetic best suited to her and her operation. Her doctor had a talk with Mrs. Peel about her treatment and operation, and explained why surgery was necessary.

Mrs. Peel learned that her jaws would remain wired into position for 3-4 weeks, but that she would be sent home during that time. She would not be able to separate her teeth. Her diet would be fluids or very soft foods until after the wires were removed. Her mouth would feel very uncomfortable and there would be excessive oral secretions immediately postoperatively. A suction machine at the bedside would help to get rid of these. Talking would be difficult and she would be given a pencil and paper to use. If at any time she felt nauseated she was to signal for the nurse at once. It was expected that everything would go smoothly, but if an emergency should arise the wirecutters attached to the bed would be used. After the wiring, oral hygiene must be even more strictly observed. Deep breathing would help to prevent lung complications and she was instructed in the method. She was also told that she would be taken to the recovery room immediately after surgery instead of returning to her ward.

Mrs. Peel adjusted to the ward quickly and seemed to accept the idea of surgery and her postoperative treatment very well. Because of difficulty in

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talking she tended to keep to herself, but with encouragement she made friends with her roommates.

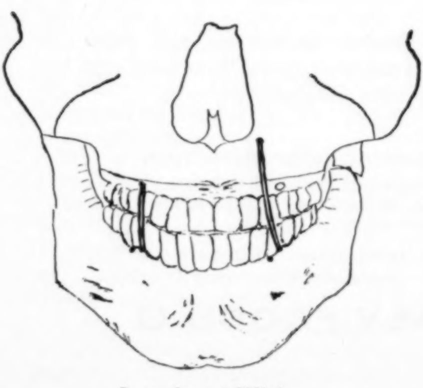
Preoperative Preparation

1. *Local*: The night before surgery the operative area was shaved and cleansed. The operation was scheduled for 11:00 A.M. so there was ample time during the morning to cleanse the mouth thoroughly several times and to clean the dentures and put them in a labelled container ready to go to the operating room with the patient. It was essential that the mouth be as clean as possible to lessen the danger of lung complications and mouth infection after surgery.
2. *Physical*: Mrs. Peel received an enema the night before surgery, and a complete bath in the morning. She was encouraged to be up walking before her preoperative hypodermic injection and told that she must remain in bed following it. Her urinalysis report showed 2-4 white blood cells, and her hemoglobin was 81 per cent or 12.0 grams.

The Anesthetic

The anesthetist ordered Seconal gr. 1½ at bedtime to give the patient a good night's sleep, and Demerol 75 mg. with scopolamine gr. 1/150 one hour preoperatively to make her drowsy and less apprehensive, to lessen secretions and to make the anesthetic induction easier.

In the operating room, 500 cc. of 5% glucose in normal saline was established and sodium Pentothal was added to induce anesthesia. General anesthetics such as Pentothal act on the brain to produce complete loss of consciousness. After the patient loses consciousness and the concentration of the drug in the body is increased, the voluntary muscles relax and the patient passes into the stage of surgical anesthesia. Sometimes other drugs, such as Flaxedil, are given. They act on the motor nerve endings to produce temporary paralysis that gives muscular relaxation without having to deepen the stage of anesthesia. Oxygen was given, and a catheter was introduced into the nares. Nitrous oxide, a gas, was used to depress the cerebral cortex and sustain the period of anesthesia. Demerol 100 mg. was given in divided doses during the period of anesthesia.



Intradental Wiring

The Operation

At operation it was found that there was a left subcondylar fracture of the mandible with displacement of the body posteriorly. The upper jaw was edentulous, and there was some splintering along the inferior border of the maxilla which accounted for the pain when the denture was in place.

A No. 24 gauge soft brass wire which was flexible but had tensile strength was used to form an eyelet, and attached to the left bicuspid region in the lower jaw and secured there. An incision was made in the left gingival labial sulcus and deepened to the pyriform fossa where the periosteum was incised and reflected. A drill hole was made through the fossa and a loop of wire was inserted and secured to the eyelet on the lower jaw. The upper denture was inserted and attached through a hook inserted into it at the time of repair to an eyelet attached to the right lower bicuspids. The jaw was securely immobilized, the dentures were firmly anchored, and there was good occlusion of the teeth.

The comminuted fragment was left in place because it still appeared to be attached to the soft tissues and therefore would retain its vitality and aid in restoring bone continuity.

An x-ray the day after surgery revealed that:

> Intradental wiring is noted holding the jaws together. The fracture of the base of the neck of the condyle is noted with outward swinging of the free end.

Clinical Communication from a pediatrician re:

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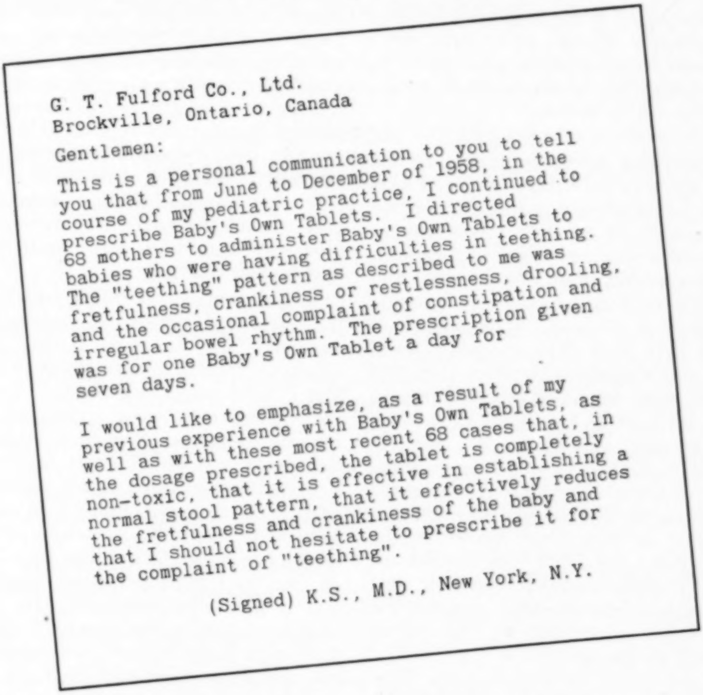
(fretfulness, drooling, constipation, etc.)



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This is a personal communication to you to tell you that from June to December of 1958, in the course of my pediatric practice, I continued to prescribe Baby's Own Tablets. I directed 68 mothers to administer Baby's Own Tablets to babies who were having difficulties in teething. The "teething" pattern as described to me was fretfulness, crankiness or restlessness, drooling, and the occasional complaint of constipation and irregular bowel rhythm. The prescription given was for one Baby's Own Tablet a day for seven days.

I would like to emphasize, as a result of my previous experience with Baby's Own Tablets, as well as with these most recent 68 cases that, in the dosage prescribed, the tablet is completely non-toxic, that it is effective in establishing a normal stool pattern, that it effectively reduces the fretfulness and crankiness of the baby and that I should not hesitate to prescribe it for the complaint of "teething".

(Signed) K.S., M.D., New York, N.Y.

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Postoperative Care

Immediately following surgery Mrs. Peel was taken on her own bed to the recovery room. Wire cutters had been previously taped to the bed ready for immediate use should the need arise. She was conscious; her blood pressure, pulse and respirations were checked at 15-minute intervals, and she was watched carefully for signs of shock or nausea. Suction equipment was ready for use if the patient showed signs of respiratory distress due to nausea or excess secretions. Mrs. Peel remained in the recovery room for two hours during which her blood pressure rose slightly. There was no oozing apparent, and no respiratory difficulties.

The doctor left the following orders:

1. Demerol 50 mg. q.4 h., p.r.n. for 24 hours.
2. Cut anchoring wire on left, if jaws need emergency opening.
3. Same diet as preoperatively.

When Mrs. Peel returned to her ward she was very drowsy. Her blood pressure, pulse, respirations and color were noted and charted. There was no sanguinous oozing from her mouth, but excess salivation was present. She was not in pain. A suction machine was kept at the bedside as well as a mouth care tray. The complete ward staff was alerted to the fact that this patient was to be given nothing to drink until 9:00 P.M., and after that, only by her own nurse for the remainder of the evening. They were asked to report immediately any signs of nausea or distress. It was thought advisable to move her nearer to the chart room so that she could be watched more carefully. Her bell cord was pinned within easy reach. She was suctioned frequently for small amounts of mucus.

Special Nursing Responsibilities

1. *Provide a free airway*: Careful observation was necessary because aspiration of vomitus or saliva would endanger the patient's life or result in atelectasis or pneumonia. The wirecutters were never taken from the bedside, and fortunately they were never needed. It was a responsibility of the nurses on each shift to know how to operate the suction and to check that it was in working order. An ounce or two of dettol solution put into the bottle after emptying and washing it made cleaning easier the next time. The amount and character of the drainage was charted.

Mrs. Peel found it easier to breathe and to get rid of secretions if the head of the bed was raised. She always had a box of celluwipes, and her discard bag was changed several times daily. A face towel was used to cover her pillow and absorb secretions that drained from her mouth during the night.

2. *Control of infection*: Strict oral hygiene was necessary to offset the effects of stagnation of secretions and a fetid breath caused by lack of normal mouth function. A child-sized tooth brush was obtained and her mouth received a thorough cleansing in the morning, following all meals, and at night. In addition applicators and hydrogen peroxide solution were used and cold cream was applied to her dry, cracked lips. By these measures postoperative parotitis, infection of the fracture area, and infection of the gums and around the wires was avoided. It also served to keep her mouth fresh and pleasant-tasting.

3. *Communication*: The position of the teeth due to the wiring, along with swelling and excess saliva made coherent speech almost impossible. A pencil and paper were used by the patient in answering questions and making requests. Frequent visits by the nurse and anticipation of the patient's needs made it much easier for Mrs. Peel to cope with the situation. Whenever possible, questions to her were phrased in such a way that "yes" or "no" was the only answer required and a nod was sufficient. Mrs. Peel seemed to enjoy the company of the staff and patients, but was very self-conscious about her condition.

4. *Relief of Pain*: The wise use of narcotics during the first 24 hours after surgery carried Mrs. Peel over the period of severe pain. The use of ice caps was found effective in overcoming some of the later discomfort. Sedation at night along with good nursing measures to make her comfortable ensured a good sleep. A crushed tablet of Aspirin and phenacetin compound with codeine gr. ½ gave relief from the occasional headaches that she

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suffered due to the constant pressure exerted on her jaws.

5. *Nutrition*: A record of intake and output and of the type of fluid taken helped us ascertain the amount of nourishment that Mrs. Peel received. Her diet proved to be quite a problem. She became discouraged, and her morale was low because of the monotony of her meals. She preferred a straw for drinking, but spoons, feeding cups and asepto syringes have been found useful.

With these patients there is often interference with carbohydrate digestion due to the reduction in ptyalin action. As a result the carbohydrate content of the diet is made lower than normal. Variety is essential. Fluids should be appetizing, properly seasoned, appeal to the eye, and be served at the proper temperature. Garnishes should be used whenever possible. Frequent small feedings were tolerated better than three meals daily as Mrs. Peel complained that she felt bloated if she attempted to take the full amount of fluid on her meal tray at one time.

The dietitians and the nurses stressed the importance of her diet and suggested ways to give variety. The dietitian made up a special milkshake and eggnog recipe for Mrs. Peel to use at home which took into consideration her nutritional requirements.

High Calorie Milkshake

Total volume 70 oz.

P.146 F.123	CHO.322	Cal. 2940
whole milk	40 oz. (5 cups)	1200 cc.
glucose	6 tablespoons	60 gm.
egg	6 medium	300 gm.
casilan	1 cup	60 gm.
salt		
ice cream	8 scoops	500 gm.
choc. syrup	6 oz. (⅔ cup)	

High Calorie Eggnog

Total volume 1 pint

milk	14 oz. (1⅔ cups)
eggs	3
glucose	2 tbsp.
skim milk powder	3 tbsp.
vanilla	
salt	

Foods that could be included on her diet were:

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cereals — as gruels thinned with milk or cream and strained; soups — any type, strained; vegetables — well cooked, pureed or creamed to thin; meats — finely ground or scraped, then sieved — may be added to soup; desserts, ice cream, jello, sherbet, custard, thin puddings; beverages — cocoa, milk, eggnog, milkshakes, juices. Strained baby foods are often found convenient to use.

This diet is expensive for the patient on a low budget. The Social Assistance department was able to give Mrs. Peel extra help. She was encouraged to weigh herself daily at home, and to try to maintain her normal weight.

6. *Emotional Support*: Mrs. Peel required much reassurance and psychological support. She had to have the fact demonstrated to her that she was socially acceptable. The nurses were careful to have the right attitude toward her treatments. Even though she seemed to accept things very well preoperatively, when actually faced with the situation Mrs. Peel tended towards depression. The nurses were faced with the problem of diverting her attention. Books and magazines helped to some extent. Praise for the way she handled her own treatments and feedings also raised her spirits. She was encouraged to become independent, and to take an interest in her treatments. Helping her to arrange her hair before visiting hours was one way for us to demonstrate our interest in her as an individual. When the sutures were removed from the lacerated areas there were only thin hairline scars. This helped to cheer her.

Three days after surgery Mrs. Peel was discharged. The wires were removed three weeks later. Her jaw was stiff for a while, but gradually exercise brought it back to normal. Her upper denture required adjusting so that it fitted snugly.

Book Reviews

Psychology, the Nurse and the Patient by Doris M. Odlum, M.A., B.A., M.R.C.S., L.R.C.P., D.P.M., 200 pages. British Book Service (Canada) Ltd., 1068 Broadview Avenue, Toronto 6. 1959. Price $2.70. *Reviewed by Mrs. E. Gibson, Nursing Counsellor, Mental Health Services, Essondale, B.C.*

There is so much diverse material crowded into the pages of this text that while the ground may be covered, it is too thinly spread to be of much use to a professional person. The material is over-simplified, superficial and sometimes open to question. For example, in Chapter Three on "Inborn Mental Factors," the author quotes extensively from William McDougall, many of whose theories are not currently accepted. The organization of material is rambling.

Much of the material refers specifically to English hospitals, their customs and community organization, and would not apply in Canada except as a matter of interest.

The last 60 pages on mental illness and the psychoneuroses are reasonably up-to-date in approach, but they deal with a subject too vast and complex to be included in a book of this type.

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VISITING NEW ZEALAND

The Twelfth Congress of the ICN, to be held in Melbourne next year, will provide many nurses with a unique opportunity to tour this area. New Zealand is only four hours' flying time from Australia. It has so many attractions that it is impossible to list them all. A tour of the country, however, will soon reveal why it is known as "a holiday world in itself."

Four alternative tours are suggested. Two of these tours precede and two follow the congress. Although one tour described here covers both North and South Islands, it is possible for tourists to arrange itineraries to take in one island only.

A comprehensive tour begins in Auckland. With a population of 422,900, Auckland is New Zealand's largest city. It is the main port of call for ocean liners and for world air services. It is a beautiful city, situated on an isthmus overlooking two fine harbors — to the east the Waitemata and to the west the Manukau. Though tourists could spend days just in and around the city visiting the many fine features that have given it the title of the "Queen City," this tour allows only one day. This permits visitors to form an impression of the extensive and beautiful parks, gardens and reserves; the magnificent civic buildings; the spacious beaches. They will gaze from the lookout on Mount Eden across the extensive waters of the Waitemata harbor, dominated by a graceful bridge linking the city with the residential North Shore area.

On the second day visitors leave the bustling city behind and pass through the lush green pastures of the Waikato to Waitomo and its world-famous glow-worm caves. This spectacle is one of the wonders of the world. The modern tourist hotel at Waitomo is only 400 yards from the caves. Guided tours are available daily. The scene in the caves, viewed from a boat, is of indescribable beauty. From a canopy of darkness overhead, the soft illumination of a million tiny lights is reflected as dim radiance by the still waters.

On the third day the tour moves from the fertile grasslands of the Waikato to the volcanic plateau in the center of the North Island. Here the party will spend two full days in and around a thermal wonderland. Rotorua is as unique as it is beautiful. Experienced world travellers maintain that it is the most spectacular thermal region in the world. Perhaps the most impressive attraction of all is the enchanting music and dancing of the Maori people. Concerts are held severay evenings a week for most of the year. In the model Pa (a Maori village) the visitor sees the novel uses to which the Maori put thermal steam. There are many examples of the intricate and impressive wood carvings which symbolize the ancient traditional figures of Maori folklore.

At Wairakei, 55 miles from Rotorua, there are two attractions which, although similar in origin, are diverse in appeal. The first of these, Geyser Valley, is an area of thermal activity that rivals Rotorua. The second, the generation of electricity from subterranean steam is an unusual experiment. Wairakei is the only place in the world where "wet" geothermal steam is used in this way.

A day in Christchurch will show visitors why the city has been called "the most English city outside England." It was planned and built around its Anglican Cathedral. Everywhere, the English influence is predominant. The Avon River, its grassy banks planted with flower beds and stately trees, winds through the heart of the city.

From Christchurch the tour moves across the Canterbury plains to the rugged southern Alps. This lofty range, towering in places to 12,000 feet, stretches the length of the South Island. From many high snowfields come the swift-flowing waters that feed numerous powerhouses or fill the placid waters of the beautiful southern lakes. The rivers are stocked with salmon and trout — fighting fish for which this area is renowned.

An alpine hotel, the Hermitage, is set in a beautiful valley with an excellent view of Mount Cook (12,349 feet). From this comfortable modern hotel, visitors can undertake all types of excursions. They can enjoy leisurely walks among virgin mountain forests or mountaineering expeditions up the varied rugged, difficult peaks. Within easy reach of the Hermitage, glacier and mountain scenery are at their best. One of the more unusual attractions of the Mount Cook area is the thrill of a scenic flight around the towering peaks in a ski-equipped aircraft that lands on snowy airstrips.

This description of the beauties of nature that the visitor to New Zealand can enjoy was prepared by the New Zealand Government Tourist and Publicity Department.

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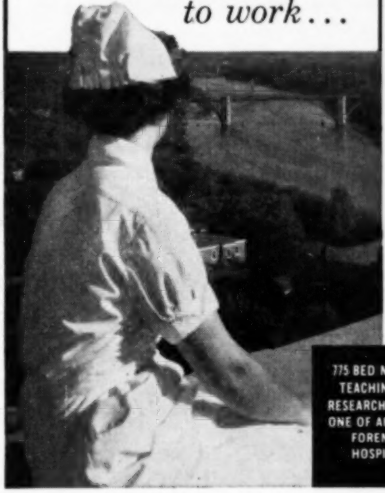

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On the ninth day the tour takes the tourist through the heart of the South Island. Queenstown is one of the most fascinating areas for holiday-makers. It lies on the eastern shore of Lake Wakatipu, which curves like the letter "S" through impressive mountain country. Frequent launch trips on the lake give the visitor an opportunity to see the scenery from the best viewpoints. Across the lake and rising 7,600 feet is the "Remarkable," a sierra-type range of mountains named for the startling color changes that occur as the sun touches the different peaks.

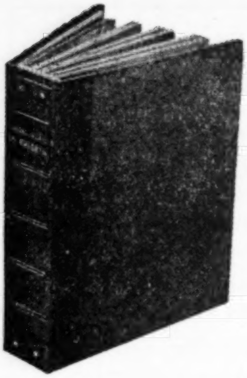
On the 11th day the tour moves to Milford Sound. For the first part of this journey the route skirts Lake Te Anau, then it runs into rugged mountain country and through the Homer Tunnel. Until this tunnel was opened the only land access to this area was by walking over the Milford Track.

Of all the famous sights of New Zealand, Milford is the one that most people regard as the finest. Everything that man has put here, and anything that man is likely to put here, is completely dwarfed by the splendor of mountains, rising almost vertically from the waters of the fiord. The modern hotel at Milford is dwarfed beneath the towering Sheerdown Range. From a cleft in a 500-foot precipice nearby the Bowen Falls plunges to a hidden pool far below.

With three days left the party leaves Milford on the 13th day and travels along the Cleddau and Eglinton Valleys back through the Homer Tunnel to Dunedin. Dunedin is the second largest city in the South Island. It is often called "The Edinburgh of the South" from its origin as a Scots settlement and its notable academic institutions. Spread over seven hills at the head of the Otago Harbor, Dunedin has all the features of a scenic city as well as those of learning. Its university and medical school have become hallmarks of professional achievement in the southern hemisphere.

The last land journey on this tour is from Dunedin to Christchurch along the eastern coastline of the South Island and through the Canterbury Plains. This is the grazing ground for New Zealand's famed export meat, prime Canterbury lamb.

TEAL air services linking Australia and New Zealand depart regularly from the airport at Harewood, Christchurch. As the airliner wings over the majestic peaks of the southern Alps, tourists will have a last look at the "backbone" of New Zealand as they cross the Tasman Sea to the shores of Australia where the congress awaits them.



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(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

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Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurse for General Duty. Starting salary $290 per mo., 6 increments of $5.00 at 6-mo. intervals. Board & room $45 per mo. For further information, phone: Boissevain 61.

General Duty Nurses for Clearwater Lake Hospital, The Pas, Manitoba. Interesting nursing with White, Indian & Eskimo patients both in general & tuberculosis wards. Starting salary $300 per mo. Good accommodation in nurses' residence. 3-wk. vacation, 40-hr. wk., 10 statutory holidays, group insurance plan. Apply: Director of Nursing Services, Sanatorium Board of Manitoba, 1654 Portage Avenue, Winnipeg, Manitoba.

NOVA SCOTIA

Registered Laboratory Technician. Good personnel policies. Apply stating experience & qualifications, to: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

Operating Room Nurse — 40-hr. wk., good starting salary. Apply to: Director of Nurses, Western Kings Memorial Hospital, Berwick, Nova Scotia.

ONTARIO

Director of Nursing for 50-bed hospital in beauty spot of lakes & rivers, cooperative & pleasant staff. 5-day wk., pension plan, salary commensurate with experience. Apply: Administrator, Huntsville District Memorial Hospital, Huntsville, Ontario.

Director of Nursing for 80-bed General Hospital, 20-mi. from London. New Hospital to be built early in 1961. Excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, or phone collect. Strathroy, Ontario.

Director of Nursing Service for 34-bed hospital (planning an extension). Salary commensurate with preparation & experience. Apply: Superintendent, Louise Marshall Hospital, Mount Forest, Ontario.

Director — Training School for Well Baby Nurses. Salary dependent upon qualifications. Also opening for **Night Supervisor.** For further information write to: Executive Director, Canadian Mothercraft Society, 341 Bloor Street West, Toronto 5, Ontario.

Assistant Superintendent, Registered Nurse for 75-bed General Hospital. Salary depending upon experience & qualifications. Residence accommodation available. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical. Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses Applications & enquiries are invited for General Duty positions on the staff of modern, well-equipped 33-bed hospital in new mining town, about 250-mi. East of Port Arthur & North-West of White River, Ontario. Excellent salary & fringe benefits, liberal policies regarding accommodation & vacation. Population 2,500. Nurses' residence comprises individual self-contained apartments. Apply, stating qualifications, experience, age, marital status, phone No. etc., to: The Administrator, General Hospital, Manitouwadge, Ontario. Phone TAylor 6-3251.

Registered Nurses, Certified Nursing Assistants for General Duty in a most modern 58-bed hospital (to be increased to 77-bed this yr.). Starting salary: R.N.'s $285 per mo. with consideration for past experience; C.N.A.'s $206 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For complete information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, General Hospital, Dryden, Ontario

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Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for all departments in a new hospital, opening in December. Good personnel policies, O.H.A. Pension Plan. Apply: Director of Nursing, Ross Memorial Hospital, Lindsay, Ontario.

TORONTO GENERAL HOSPITAL

REQUIRES

Registered Nurses and Certified Nursing Assistants

for Medical and Surgical Services

including newly opened Neurosurgical and Cardiovascular Units

Rewarding Experience — Excellent Personnel Policies

For information write to:

Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario

PROFESSIONAL SECRETARY

required by

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

This is a new position involving general office supervision, responsibility for certain committees, assisting the Executive Secretary and deputizing for other professional staff as required. Position open immediately.

Qualifications —post-basic nursing education desirable.

Experience —at least five years nursing experience, including supervisory and/or administrative — some knowledge of community health and welfare organizations, — business experience desirable.

Salary range —from $400 to $486 per mo.; other benefits in accord with RNABC personnel policies.

Applications or enquiries may be addressed to:

EXECUTIVE SECRETARY, REGISTERED NURSES' ASSOCIATION OF B.C.
2524 CYPRESS ST., VANCOUVER 9, B.C.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in modern 42-bed hospital. Starting salary $265 & $180 respectively, plus shift allowances. Deduction for room & board $30. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty. Initial gross salary $270, 40-hr. wk., modern nurses' residence, good personnel policies, pension plan. Apply: Superintendent, Louise Marshall Hospital, Mount Forest, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital, in iron mining town, 150-mi. north of Sault Ste. Marie, Ontario. Starting salary $281 min. to $316 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered General Duty Nurses for 34-bed General Hospital. Good salary & personnel policies, 40-hr. wk. Adjacent attractive residence, recreation facilities. For further particulars, apply: Miss A. Burnett, Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

Registered General Duty Nurses for 76-bed General Hospital in small town, 16-mi. from Sarnia. Good personnel policies in effect. Limited residence accommodation available. Apply to: Administrator, Charlotte Eleanor Englehart Hospital, Petrolia, Ontario.

General Duty Registered Nurses & Certified Nursing Assistants for 75-bed General Hospital on Lake of the Woods. Starting salary for nurses currently registered in Ontario $275-$305, for Nursing Assistants holding Ontario certificate $190-$220, full maintenance $50 monthly. Apply to: Superintendent, General Hospital, Kenora, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurse Starting salary $270 per mo. **Charge Nurse** salary $300 per mo. for 50-bed hospital, resort area. 5-day wk. Apply: Administratrix, Huntsville District Memorial Hospital, Huntsville,, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $270 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

WORLD HEALTH ORGANIZATION

requires experienced Nurse Educators for senior adviser posts in:

1) **SIERRA LEONE and GHANA** To help plan basic and post-basic nursing education programs, based upon surveys of local needs.

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The salary range for each of these posts is US $6,000 - $8,000 per annum (net of tax), plus allowances.

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Initial contracts are for two years. Travel to and from duty stations is paid by the Organization. Paid home leave may be taken at 2-year intervals, subject to renewal of contract.

Applications may be made to:

PERSONNEL OFFICE, WORLD HEALTH ORGANIZATION,
PALAIS DES NATIONS, GENEVA, SWITZERLAND

THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Duty Staff Nurses for 80-bed hospital, 20-mi. from London. Accommodation available in residence, excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, Strathroy, Ontario.

General Duty Nurses for operating room in 285-bed hospital. 40-hr. wk., 8 statutory holidays, 3-wks. vacation, sick time allowance. For further information, apply: Director of Nursing, Wellesley Hospital, 160 Wellesley Street, East, Toronto 5, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurse (Immediately) for home visiting in a child health research project in London. Car required, starting salary $3,200 plus mileage allowance. Apply to: Dr. Carol Buck, U.W.O. Medical School, 346 South Street, London, Ontario.

Nurses (2) for United Church Mission Hospital in northern British Columbia. Salary $285 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia. or** Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Avenue East, **Toronto, Ontario.**

P.E.I.

Director of Nursing Education, degree preferred, **Medical-Surgical Clinical Instructor, Nursing Arts Instructor,** for school associated with 200-bed hospital, salary based on qualifications & experience. Apply to: Director of Nursing, Prince Edward Island Hospital, Charlottetown, Prince Edward Island.

BERMUDA

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Clinical Instructor in Rehabilitation Nursing and Rehabilitation Nurse for expanding program in a New England rehabilitation facility. Full details upon request. Write Box N, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $275 per mo. 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

General Duty Nurses for Obstetrical Service. Apply: Director of Nurses, Jeffery Hale's Hospital, Quebec City.

Residence, Cook County School of Nursing

NURSES WHO LIVE
HERE NEVER STOP
LEARNING . . .
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COOK COUNTY HOSPITAL

. . . in one of the Largest
Most Stimulating Medical
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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a 37½ *hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

OPERATING ROOM NURSES

For expanding 374 bed General Hospital located on Long Island Sound just 45 minutes from New York City.

- Starting salary $355, annual increases for four years.
- $15 bonus paid for each night on call.
- Paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, Social Security.
- Scholarship paid available for continued collegiate study.

Apply: Operating Room Supervisor

NEW ROCHELLE HOSPITAL, NEW ROCHELLE, NEW YORK

Operating Room Nurses for modern well-equipped department in 140-bed General Hospital, no rotation, but required to take night calls. Good personnel policies & salary in accordance with ANPQ recommendations. Apply: Director of Nursing, Reddy Memorial Hospital, 4039 Tupper Street, Montreal, Quebec.

SASKATCHEWAN

Operating Room Supervisor with postgraduate training, for 180-bed hospital. Average monthly surgical load - 157. Basic Salary $335 per mo. Duties consist of administration of department & educational program of students in department. Apply stating qualifications & experience to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Obstetrical Supervisor for 225-bed General Hospital, good personnel policies. For further information contact: Director of Nursing, Union Hospital, Moose Jaw, Saskatchewan.

Registered Nurses (2) for 19-bed hospital at Vanguard, Sask. Salary range $280 - $355. One year's experience $295 - $355. 3-wk. vacation, sick leave, residence on grounds with T.V. Apply to: The Secretary, Vanguard Union Hospital, Vanguard, Saskatchewan.

Registered Nurses for General Duty in Medical & Surgical Wards. Salary $270-$345, good personnel policies & liberal holiday allowance. Apply: Director of Nursing, Providence Hospital, Moose Jaw, Saskatchewan.

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living accommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accumulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital, Leader, Saskatchewan.

Registered General Duty Nurses (2) for modern 7-bed company hospital. Salary $315 per mo., $10 accredited postgraduate courses, overtime paid, $25 increment after 1 year. Full maintenance, transportation paid from point of hire in exchange for 1 year service. Group insurance & attractive vacation benefits. Excellent recreational facilities, boating, fishing, swimming, bowling, etc. Apply: Miss N. Prefontaine, R.N., Matron, Gunnar Mines Hospital, Uranium City, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff & Supervisory permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40 hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $335 - $395, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.

THE
VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks vacation.

Salary $285 - $342 per month
with consideration for experience or special preparation.

Please apply to:

PERSONNEL DEPARTMENT,
10TH AVENUE AND WILLOW STREET,
VANCOUVER 9, BRITISH COLUMBIA.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS' HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.
SHAUGHNESSY HOSPITAL, VANCOUVER, B.C.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence—for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg.
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

GENERAL DUTY NURSES

required by

The Dauphin General Hospital Ultra-modern 100 bed hospital in process of construction located in the beautiful Riding Mountain Resort area of Manitoba. 40 hour week, excellent personnel policies. Residence facilities, minimum starting salary $280 per month, assistance with transportation given if necessary.

Apply to: Superintendent of Nurses

DAUPHIN GENERAL HOSPITAL
DAUPHIN, MANITOBA

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of Nurses, General Hospital, Tulare, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $341 - $426 mo. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Nurses — San Joaquin General Hospital, a teaching hospital with internes, residents, & school of professional nursing. Positions available on most services on all shifts. Starting salary $376 per mo., differential for evening & nights. Laundry uniforms $5.00 per mo., liberal personnel policies, living facilities for single persons on hospital grounds. Contact: Personnel Director, 732 East Main Street, Stockton, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $330 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Good salary, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi. from Boston. Living quarters available. Minimum starting pay $70 R.N.'s., L.P.N's. $58 per wk. Experience considered, differentials for reliefs, nights. Contact: Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Graduate Nurse for 59-bed accredited community hospital, 35-mi. from either Philadelphia or Atlantic City. Salary $300 plus. Full time, 3 to 11 shift, good personnel policies. Write: Administrator, Community Hospital, Elmer, New Jersey.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON,
TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

HEAD NURSE FOR NEW PSYCHIATRIC UNIT TO BE OPENED IN FROM FOUR TO SIX MONTHS.

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Supervisors — Medical-Surgical, Pediatrics, Obstetrics & Psychiatric. Base salary $400 to $439, depending upon preparation & experience. Liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs. Housing available on campus or in vicinity of hospitals. Apply: Director Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of Oregon medical school. Salary starts at $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland I, Oregon.

Staff Nurses: Are you interested in working in a fully accredited 71-bed hospital with high standards of patient care? For complete information write to: Director of Nursing, Gifford Memorial Hospital, Randolph, Vermont.

General Duty Nurses for fully approved 390-bed County Hospital, affiliated with University schools of Medicine & Nursing. Starting salary $345, 40-hr. wk., liberal shift differential & other policies. For information write: Director Nursing Service, King County Hospital, Seattle 4, Washington.

Operating Room Supervisor for 238-bed JCAH approved hospital. Intern, Resident & Nursing Education programs. Candidates with BS degree preferred. Apply to: Mrs. Virginia Krahl, Director of Nursing Service, Cottage Hospital, 320 West Pueblo Street, Santa Barbara, California.

BRITISH COLUMBIA

Operating Room Supervisor for modern 125-bed Regional Hospital. Includes C.S.R. & Emergency. Basic 1961 salary $342 plus increments for experience & qualifications. Experience & initiative needed. Apply: Director of Nursing, Regional Hospital, Prince George, British Columbia.

MANITOBA

Registered Nurses for active 28-bed hospital. Daily bus to & from Brandon; 6-mi. to main line of C.N.R. Basic salary $290 with increments to $330, past experience recognized, 5-day wk., 10 statutory holidays, 3-wk. vacation after first year. Residence accommodation available, board & room $50 per mo., uniforms laundered free. Apply immediately to: Miss M. G. Dunn, Hamiota District Hospital, Hamiota, Manitoba.

Registered & Licensed Practical Nurses. Salary rating for Registered Nurses, min. $281 - max. $319 per mo. with $10 additional for evening duty; for Licensed Practical Nurses min. $218 - max. $242 per mo. 8-hr. duty (day, evening or night), 40-hr wk. Living accommodation available. Apply in writing to: The Personnel Office, Municipal Hospitals, Morley Avenue East, Winnipeg 13, Manitoba.

ONTARIO

Director of Nursing for a new 66-bed hospital in Georgetown, Ontario, to be opened on June 1, 1961. Preference will be given to an applicant holding a degree in nursing supported by practical experience in a General Hospital. Duties to commence March 1, 1961. Please reply giving full particulars, including salary expected, to: Georgetown & District Memorial Hospital, Georgetown, Ontario.

Registered Nurses — starting salary $295 monthly, annual increments $10 per mo. to a maximum of $340, 28 days vacation after 1 year, room & board available in nurses' residence $45 monthly. Travel expenses refunded after 6-mo. employment. Apply: Director of Nursing, General Hospital, Atikokan, Ontario.

QUEBEC

General Duty Registered Nurses will be required in order to open two new wards at the Montreal Children's Hospital in January 1961. Good personnel policies & orientation program. Salary allowance for experience & postgraduate courses. Apply: Director of Nursing, Montreal Children's Hospital, 2300 Tupper Street, Montreal 25, Quebec.

ENGLAND

Plastic Surgery, Jaw Injuries & Burns Centre, St. Lawrence Hospital, Chepstow, Mon. England. (127-Plastic Surgery, 50-Orthopedic beds). 6-mo. postgraduate course on Plastic Surgery for Canadian trained nurses commences April 1st. Post provides opportunity of gaining further experience & seeing something of England. Full national Staff Nurses' salary paid (£498 a year, less £180 for board residence). Good knowledge of English essential & must pay own fare to England. This post provides an opportunity for those who wish to take a working holiday with pay. Write quoting 2 references to T. A. Jones, Group Secretary, 64 Cardiff Road, Newport, Mon. England.

REGISTERED NURSES — CERTIFIED NURSING ASSISTANTS

Modern 200-bed General Hospital with new wing under construction; located in the Garden City of Canada adjacent to American Cities and close to Toronto and Hamilton.

Good salary, 40 hour week with half-yearly increments — participation in payment of hospitalization, pension, and group life insurance — three weeks' vacation and statutory holidays. Copy of personnel policy available on request.

Apply:

DIRECTOR OF NURSING,
HOTEL DIEU HOSPITAL, ST. CATHARINES, ONTARIO.

DIRECTOR OF NURSING

Director of Nursing wanted. Modern 750-bed accredited civic General Hospital (200-bed addition being built). Responsible position. To plan and direct education of (300 Student Nurses) and service programs. Perquisites include suite with service, pension plan, four (4) weeks vacation, sick benefits. Salary $7,000 - $9,000 annually depending upon qualifications and experience. Duties to commence as soon as possible.

Address replies to:

CHAIRMAN, CALGARY HOSPITALS BOARD,
CALGARY GENERAL HOSPITAL, CALGARY, ALBERTA.

CITY OF BELLEVILLE — HEALTH DEPARTMENT

SUPERVISOR *required for Generalized Program*

Blue Cross 50% paid by City — Pension, Group Insurance and cumulative sick leave available. Four (4) weeks vacation.

Car provided if required or car allowance.

Salary — $4,500 - $5,500 — depending upon qualifications and experience, annual increments.

Apply to:

MEDICAL OFFICER OF HEALTH,
266 PINNACLE STREET, BELLEVILLE, ONTARIO.

NURSING CONSULTANT (HOSPITAL INSURANCE)

required by

Department of National Health and Welfare, Ottawa
$7,500 - $8,700

Duties will involve advising on nursing services as related to hospital services in Canada, acting as consultant to provincial health and hospital insurance authorities on nursing aspects related to hospital services within the provinces and developing plans and techniques for the improvement of nursing services in hospitals.

Candidates must possess a **Baccalaureate Degree in Nursing**, registration in a province of Canada, at least ten years of acceptable experience, some in positions of leadership, and a broad knowledge of nursing in Canadian Hospitals.

For details write to

CIVIL SERVICE COMMISSION, OTTAWA.
Please ask for Information Circular 60-897.

THE NATIONAL HOSPITAL

Queen Square, London, W.C.1., England

(MEDICAL NEUROLOGY AND BRAIN SURGERY)

ADVANCED NURSING EDUCATION

One year courses are open to graduates of accredited Schools of Nursing having good educational background.

Three months academical teaching in the School of Nursing under guidance of Sister Tutor assisted by large teaching Staff of Senior Neurologists and Neuro-Surgeons.

Eight months Clinical experience, one month vacation.

Certificate and badge of the hospital awarded to successful students. Full graduate salary paid throughout the year. This work has a special appeal to nurses interested in research and the humanitarian aspect of Nursing.

Apply to:

MATRON FOR FURTHER PARTICULARS.

BURLINGTON, ONTARIO

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

are needed for
a new 225 bed hospital
to be opened
February 1961

For information, write to:

DIRECTOR OF NURSING
JOSEPH BRANT MEMORIAL HOSPITAL
1240 NORTH SHORE BLVD.,
BURLINGTON, ONTARIO

GUELPH GENERAL HOSPITAL

Active — 200 beds — Fully Accredited

Requires

GENERAL STAFF NURSES

Pleasant city of 38,000 close to larger centers

Excellent salary and personnel policies

For further details apply to:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
GUELPH, ONTARIO.

McKELLAR GENERAL HOSPITAL

School of Nursing

will have openings for
INSTRUCTORS
in Medicine, Surgery and Pediatrics
by July 15th, 1961

Qualified applicants are invited to apply:

Salary commensurate with experience and qualifications.

Apply to:

DIRECTOR,
McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

DIRECTOR OF NURSING

POSITION OPEN

111-BED MODERN HOSPITAL IN GROWING COMMUNITY ON VANCOUVER ISLAND.

APPLY WITH RECORD OF EXPERIENCE, TRAINING AND REFERENCES TO:

H. E. TAYLOR, ADMINISTRATOR,
WEST COAST GENERAL HOSPITAL, PORT ALBERNI, BRITISH COLUMBIA.

EDUCATIONAL DIRECTOR

FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

Present plan to enrol first class of students for September 1961. Director required at once to facilitate planning an educational program and arranging for staff.

Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

Apply:

DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,
REGENT STREET SOUTH, SUDBURY, ONTARIO.

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

INSTRUCTOR IN PEDIATRIC NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include clinical and classroom instruction.

Requirements: University preparation in Nursing Education

Salary differential for degree.

For further information apply to:

DIRECTOR, SCHOOL OF NURSING, 2240 KILDARE RD., WINDSOR, ONT.

GENERAL DUTY NURSES (2)

FOR A MODERN, NEW 25-BED HOSPITAL

3 doctors on staff. 9 Registered Nurses, 3 Nursing Assistants, 1 Laboratory Technician, 1 X-Ray Technician. 5 day 40-hour week. No split shifts, 3 weeks vacation after one year service, 9 statutory holidays. Salary $280-$380. Single rooms in modern nurses' residence with television. Board and room $1.15 per day, laundry free. Established personnel policies. Apply in writing to:

JANIE SUTHERLAND, SUPERINTENDENT OF NURSES,
UNION HOSPITAL, P.O. BOX 760, ESTON, SASKATCHEWAN.

ADVISER TO SCHOOLS OF NURSING

The Saskatchewan Registered Nurses' Association

invites applications for the position of

ADVISER TO SCHOOLS OF NURSING

Applicants must possess a degree in nursing and have a minimum of five years experience in nursing education and nursing service of which the major portion has been in nursing education.

Apply in writing stating qualifications, experience and salary expected to:

MISS LOUISE MINER,
PRESIDENT, S.R.N.A.
5 BARTLEMAN APT.,
REGINA, SASKATCHEWAN.

A job description is available

KINGSTON GENERAL HOSPITAL

invites applications for position of

DIRECTOR OF NURSING

The hospital is situated in the cultural and historic city of Kingston. The new Connell Wing recently opened increased bed capacity to 625. A modern, new cafeteria, with a nurses' training school completes a brief picture of this fully accredited General Hospital. Salary is dependent upon qualifications and experience. Excellent personnel policies with 4 weeks annual vacation, pension and medical plans.

For further information address inquiries to:

SUPERINTENDENT
KINGSTON GENERAL HOSPITAL
KINGSTON, ONTARIO

HAMILTON GENERAL HOSPITALS

Invite applications from Graduate Nurses for the position of

CLINICAL INSTRUCTOR

at the Mount Hamilton Hospital to take charge of postgraduate program in OBSTETRICAL NURSING. Applicant must have at least one year postgraduate study at recognized university. Good personnel policies. Salary acording to qualifications and experience. Applications to be forwarded to:

SUPERINTENDENT OF NURSING,
MOUNT HAMILTON HOSPITAL,
CONCESSION STREET,
HAMILTON, ONTARIO.

VICTORIA HOSPITAL

LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

DIRECTOR OF NURSING
VICTORIA HOSPITAL
LONDON, ONTARIO.

JEWISH GENERAL HOSPITAL

MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for Administration and General Duty and also for Certified Nursing Assistants. Instructor with post-basic preparation in Nursing Education required for School of Nursing. Excellent personnel policies. Salary in accordance with The Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

GENERAL DUTY NURSES

$335 per month, annual increment $10 monthly. 40-hour week, paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, Social Security.

Scholarship aid available for continued collegiate study.

Apply: Superintendent

ALEX. E. NORTON
NEW ROCHELLE HOSPITAL, NEW ROCHELLE, NEW YORK

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

CLINICAL INSTRUCTOR

FOR OPERATING ROOM

NEW ROCHELLE HOSPITAL
NEW ROCHELLE, NEW YORK

•

B.S. DEGREE REQUIRED

•

Salary depending on experience

APPLY TO: OPERATING ROOM SUPERVISOR

NOTRE DAME HOSPITAL OF MONTREAL

NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 10 days; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year, Pension plan.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

PROVINCE OF ALBERTA

EMPLOYMENT OPPORTUNITY

GENERAL DUTY NURSES

Salary - $3,480. to $4,080. per annum. 40-hour week, Civil Service holiday, sick leave and pension programs.

DEPARTMENT OF PUBLIC HEALTH
Baker Memorial Sanatorium
Calgary, Alberta

Apply, giving full details, to the Baker Memorial Sanatorium, Calgary, Alberta.

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL, SURGICAL & OBSTETRICAL DEPARTMENTS

Apply

EDITH G. YOUNG, REG.N.,
ASSISTANT ADMINISTRATOR - NURSING

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

GENERAL DUTY NURSES

WANTED

Salary — $265 - $315 per month 40-hour week, no split shifts.

Vacation — 3 weeks after one year; statutory holidays — eight (8); sick leave — cumulative from date of employment

Transportation — advanced on repayable basis For 75-bed fully accredited hospital built in 1956, located in south-western Ontario.

Apply to: Director of Nursing,

SYDENHAM DISTRICT HOSPITAL
WALLACEBURG, ONTARIO

ASSOCIATE DIRECTOR OF NURSING

CALGARY GENERAL HOSPITAL

invites applications for the position of Associate Director of Nursing, Modern 750-bed accredited civic General Hospital (200 bed addition being built). Duties to commence as soon as possible. Salary range $5,000 - $6,500 per year depending upon qualifications and experience. Liberal benefits and personnel policies.

Address replies to:

ADMINISTRATOR,
CALGARY GENERAL HOSPTAL,
CALGARY, ALBERTA.

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH

B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY $346-$405 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, write to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION NO. 60:484.